



Provider Administration Manual

For BlueCare Plus Tennessee Network



Effective April 1, 2026

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I. Introduction

Volunteer State Health Plan, BlueCare Plus Tennessee (BCPTN), is contracted with Centers for Medicare and Medicaid Services (CMS) to offer Dual Special Needs Plans to beneficiaries in the state of Tennessee. Coverage under BlueCare Plus Tennessee includes three plan options: BlueCare Plus Fully Integrated Dual Eligible Special Needs Plan (HMO D-SNP)SM, BlueCare Plus Choice Fully Integrated Dual Eligible Special Needs Plan (HMO D-SNP)SM, and BlueCare Plus Select (HMO D-SNP)SM. The reference to BlueCare Plus Tennessee will refer to all three BlueCare Plus TN Plans, Plus, Choice, and Select. Dual eligible are some of the most vulnerable members of the Tennessee population due to a combination of low income, social determinants of health, and a high incidence of chronic health conditions.

BCPTN is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. BCPTN is designed specifically for people who have Medicare and who are also entitled to assistance from TennCare (Medicaid).

The requirements, policies and processes defined in this Provider Administration Manual (PAM) are a contractual obligation as stipulated in either the stand-alone BCPTN Agreement or a BCPTN Amendment to the BlueCare /TennCare Select Agreements.

Changes to this Manual will be communicated to providers at least thirty (30) days prior to implementation (excludes medical policy changes driven by new technology). Such changes will be communicated using one or more of the following resources:

- *BlueAlert* Monthly Provider Newsletter
- Quarterly Provider Manual updates
- Online updates to Medical Policy Manual accessible on company websites, www.bcbst.com or bluecareplus.bcbst.com
- Individual Provider Mailings

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by BlueCross BlueShield of Tennessee (BCBST), including its licensed affiliate, BCPTN.

Furthermore, no person shall be subjected to any form of retaliation to include threats, coercion, intimidation, or discrimination because of filing a complaint, testifying, assisting or participating in an investigation, proceeding or hearing.

A. BlueCare Plus Tennessee Statement of Purpose

BUSINESS

BCPTN has been serving Tennessee residents who are eligible for both Medicare and Medicaid since 2014.

PURPOSE

Local Solutions, Meaningful Results.

LONG-TERM CORPORATE GOALS

Our Long-Term Corporate Goals are:

- Affordability

- Sustainability
- Outreach

MISSION

BCPTN Model of Care (MOC) is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care through coordination of care for members with complex, chronic or catastrophic health care needs. Care coordination support teams work with each member to access the most appropriate services to meet physical, behavioral health, long-term care and social needs.

BCPTN's Care Coordination Team is responsible for the development of a member's Individualized Care Plan (ICP). The core composition of the member's Interdisciplinary Care Team (ICT) is an important component of the integrated care programs for our members and/or natural supports caregiver, Care Coordination Team, PCP and/or other treating providers. Ongoing communication and collaboration within the Care Coordination Team and the member's ICT is essential to ensure all parties are effectively managing the care for BlueCare Plus Tennessee members.

BCPTN is committed to excellence. Customer service is more than answering questions quickly and correctly. Customer service is the very heart of BCPTN, talking personally, individually, to our members, making sure each member receives the particular services needed. We work as a liaison between members and providers, helping customers access their benefits and assisting providers in coordinating and managing members' care.

B. Code of Business Conduct

We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, BCPTN adopted a set of policies and Code of Conduct that applies to all employees, officers, contracted vendors, and members of the Board of Directors. We are willing to share our own Code of Conduct, along with related policies and procedures, with our business partners in order to relay our commitment to a corporate culture of ethics and compliance. The Code of Conduct sets an ethical tone for the organization and provides guidelines for how our business partners and BCPTN are expected to conduct business.

We encourage suppliers and third parties with whom we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud.

Included in our Code of Conduct are two sections entitled "Conflicts of Interest" and "Dealing with Customers, Suppliers, and Third Parties". The primary focus of these sections is to help ensure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our professional responsibilities should be avoided. You may review the Code of Conduct in its entirety online at [vshpcodeofconduct.pdf](#)

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation, please call the Confidential Compliance Hotline, 1-888-343-4221 or e-mail us at compliancehotline@bcbst.com.

C. Provider Manual Requirements

BCPTN is required to explain certain categories in the provider manual. A listing of the topics is included below.

Category	Page #	Category	Page #
Description of the BCPTN Program	10	Covered Services	92
Member Appeal Rights	195	Provider Complaint System	208
PCP Responsibilities	32	Coordination with other Contractors/ Subcontractors	22
Emergency Service Responsibilities	93	Services and Standards	26
Prior Authorization	132	Referral Requirements	99
Care Management	126	Provider Appeals	208
Encounter Data Reporting	145	Utilization Management Requirements and Procedures	132
Medical Records Standards	188	Claims Submission Standards	144

D. Statutory and Regulatory History

BCPTN's Care Coordination Team is responsible for the development of a member's Individualized Care Plan (ICP). The core composition of the member's Interdisciplinary Care Team (ICT) is an important component of the integrated care programs for our members and/or natural supports caregiver, Care Coordination Team, PCP and/or other treating providers. Ongoing communication and collaboration within the Care Coordination Team and the member's ICT is essential to ensure all parties are effectively managing the care for BCPTN members.

BCPTN serves members who are dually eligible for Medicare and Medicaid within the BCPTN service area.

1. The Medicare Improvements for Patients and Providers Act (MIPPA)

The Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110–275), enacted on July 05, 2008, called upon the Health and Human Services (HHS) Secretary to revise the marketing requirements for Part C and Part D plans in several areas. MIPPA also enacted changes with respect to Special Needs Plans (SNPs), Private Fee-For-Service plans (PFFS), Quality Improvement Programs, the prompt payment of Part D claims, and the use of Part D data. With the exceptions noted in the final rule, MIPPA required that these new rules take effect at a date specified by the Secretary, but no later than November 15, 2008.

Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the SNP provider to enter into an agreement with the State to provide or arrange for Medicaid benefits to be provided to its Dual Eligible enrollees. MIPPA provides for coordination of services between Medicare and Medicaid for full benefit dual eligible members. The Care Coordination Team is responsible for coordinating and ensuring continuity and coordination for physical and behavioral health among LTSS members.

The final rule established the MIPPA related provisions of the September 18, 2008, IFC (73 FR 54226), November 14, 2008, IFC (73 FR 67406), November 21, 2008, correction notice (73 FR 70598), and one provision on two SNP-related statutory definitions that was finalized with a comment period in the January 16, 2009 final rule with comment period (74 FR 2881).

2. Special Needs Plan

The Dually Eligible Special Needs Plan (D-SNP) enrolls members who are entitled to both Medicare (Title XVIII) and Medical Assistance from the State under Title XIX (Medicaid) and offers the opportunity of enhanced benefits by coordinating those available through Medicare and Medicaid. The program is designed to promote the integration and coordination of Medicare and Medicaid benefits through a single managed care organization, while ensuring full access to seamless high quality health care and to make the system as cost effective as possible.

The Affordable Care Act created requirements for D-SNPs:

- Provide dual eligible members access to Medicare and Medicaid benefits under a single managed care organization;
- Coordinate delivery of covered Medicare and Medicaid health and long-term care services;
- Possess a valid capitated contract with the State for specified primary, acute, and long-term care benefits consistent with State policy; and
- Comply with CMS and State policy regarding marketing, appeals, quality assurance, and enrollment communication procedures.

Additionally, the Affordable Care Act authorized the creation of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP). FIDE SNPs provide states with additional authority and flexibility to achieve a higher degree of integration of administrative alignment and of Medicare and Medicaid services. FIDE SNPs offer the highest level of benefit and administrative integration. BCPTN's FIDE SNP plans are called BlueCare Plus (BCP) and BlueCare Plus Choice (BCPC).

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II. Administrative

Development of the Medicare special needs plans are to provide more focused and specialized healthcare for people who require health benefits tailored to their specific needs and conditions. The plans are available to Medicare and Medicaid members who have chronic, severe or disabling medical conditions. BCPTN is a person-centered approach to coordinated care for special needs members.

The program promotes quality and cost-effective coordination of care for BCPTN members with chronic, complex, and complicated health care, social service and long-term care needs. Care Coordination involves the systemic process of assessment, planning, coordinating, implementing and evaluating care received through fully integrated physical and behavioral health to ensure the care needs of the member are met.

A. General Information

Member Service Line	1-800-332-5762
Provider Service Line	1-800-299-1407
Fax Line	1-888-309-7093
Prior Authorization for Medical	1-866-789-6314
Prior Authorization for Medical Fax	1-866-325-6698
Prior Authorization for Behavioral Health	1-866-789-6314
Prior Authorization for Behavioral Health Fax	1-866-325-6698

1. Interpretation Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to BCPTN and it is not permissible to charge a BCPTN member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at

https://www.fhwa.dot.gov/civilrights/programs/title_vi/guidance.cfm.

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of BCPTN members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at

<https://www.lep.gov/sites/lep/files/resources/ISpeakCards2004.pdf>.

Additional recommended resources for use when LEP services are needed, or providers cannot locate interpreters specializing in meeting needs of LEP clients may include the following:

- Language Line 1-800-874-9426
- AVAZA Language Services 1-800-482-8292
- Institute of Foreign Language 1-615-741-7579

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and

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- Using qualified bilingual volunteers.

2. Health Literacy and Cultural Competency Provider Tool Kit

Health Literacy and Cultural Competency are important issues facing health care providers. It is important for organizations to have and utilize policies, trained and skilled employees and resources to anticipate, recognize and respond to various expectations (language, cultural and religious) of members and health care providers.

BCPTN through collaborative efforts with the Division of TennCare offers a Health Literacy and Cultural Competency Provider Tool Kit providing health care professionals additional resources to better manage members with diverse backgrounds. The Tool Kit may be accessed on the company website at https://bluecare.bcbst.com/forms/Provider%20Forms/Cultural_Awareness.pdf

3. Important Contact Information

BCBST produces the BlueAlert newsletter monthly to communicate important policy and benefit-related news to health care Providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BCBST. Current and archived BlueAlert issues can be viewed on the company website under the News and Updates section at <https://provider.bcbst.com/news-updates>

Providers are also encouraged to visit the company website, www.bcbst.com to verify member eligibility, benefit coverages and check claims status in a secure area.

Contact	Phone Number	Address or Description
Provider Relations:		
Statewide	1-800-924-7141 – Option 2	Provider Relations 1 Cameron Hill Circle, Chattanooga, TN 37402
Provider Service Line		
eBusiness Solutions Technical Support (Availity, Electronic billing, EFT, ERA)	423-535-5717 – Option 2	BlueCross BlueShield eBusiness Solutions 1 Cameron Hill Circle Chattanooga, TN 37402
Care Management		
Member Nurse Line	1-888-747-8951	Available 24-hours-a-day, 7-days-a-week
Health Care Counseling	1-800-262-2873	
Inpatient/Outpatient Behavioral Health	1-866-789-6314	All inpatient and some specific outpatient behavioral health care services require prior authorization.
Pharmacy Program – Prior Authorization	1-800-299-1407	
State of Tennessee		

Division of TennCare Eligibility	1-800-852-2683 https://www.tn.gov/tenncare/providers/verify-eligibility.html	Division of TennCare
Family Assistance Service Center	1-866-311-4287	310 Great Circle Rd., Nashville, TN 37243
Family Assistance Service Center – Nashville	1-615-743-2000	Nashville Area Only
Office of Inspector General	1-800-433-3982	To report suspected fraudulent activity.
Crisis Hotline Adults (18 years and older)	1-855-274-7471	To obtain immediate assistance in a crisis.
Children & Youth (under 18 years of age)-See Region for number	1-800-690-1606	
Memphis Region	1-866-791-9226	
Rural West TN	1-866-791-9227	
Rural Middle	1-866-791-9222	
Nashville Region	1-866-791-9221	
Southeast TN	1-866-791-9225	
Knoxville Region	1-866-791-9224	
Northeast TN	1-866-791-9228	
Medicare	1-800-MEDICARE	
TennCare Connect	1-855-259-0701	

B. Compliance

1. Protected Health Information-allowable disclosures under HIPAA

Privacy of medical information is important to all covered entities, federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BCPTN operates, however, it will not prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).

BCPTN will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information, and BCPTN providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of BCPTN members available to each physician and/or health care professional treating BlueCare Plus Tennessee BCPTN members.

Privacy regulations should not affect patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to

misconceptions about allowable exchanges of information for TPO. The following offers examples of TPO, which include, but are not limited to:

- **Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.
- **Payment** - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.
- **Health care operations** - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html>

If you have any questions or concerns regarding privacy matters, you may contact the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail at privacy_office@bcbst.com.

2. Fraud and Abuse

A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating provider or member, can report suspected health care fraud by calling BlueCross BlueShield of Tennessee Fraud and Abuse Hotline at 1-888-343-4221 or submitting a confidential tip online at www.bcbst.com/fraud/index.page.

3. False Claims Act

The following information pertains to the Federal False Claims Act (Title 31, Section 3729):

Civil Liability for Certain Acts. — A person is liable under the Federal False Claims Act, who—

- Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

Civil Penalties and Damages

- Civil penalty of not less than \$5,000 and not more than \$10,000,

- Cost of litigation; and
- Damages of 3 times the amount of damages which the Government sustains because of the act of that person, except that the court may assess not less than 2 times the amount of damages which the Government sustains if the court finds that:
 - The person committing the violation furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the person (defendant) first obtained the information;
 - The person fully cooperated with any Government investigation of the violation; and
 - At the time the person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under Title 31 of the United States Code with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

Whistleblower

- Whistleblower provision
 - Individuals with original information regarding fraud involving government health care programs may file a lawsuit.
 - As used in this section, Whistleblower – means an employee who discloses suspected fraud or abuse by his/her employer to a government or law enforcement agency.
- Whistleblower successful lawsuit
 - Must meet specific legal requirements.
 - Possibly awarded 15 percent to 30 percent of total recovered.
 - Employee are protected from retaliation.
- Whistleblower protection from retaliation
 - Employee must reasonably believe he/she is reporting a violation of the law.
 - Employer cannot discharge, demote, suspend, harass, or in any manner discriminate against the employee whistleblowing.
- Employer Liability for Retaliation Against Whistleblower
 - Reinstatement of job with same seniority status;
 - 2 times back pay, plus interest on back pay;
 - Litigation costs and attorneys' fees; and
 - Any other special damages sustained by the Whistleblower.

Criminal Liability for Certain Acts.

Improper Benefits

A person commits a Class E felony who knowingly obtains or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, an Improper Benefit. As used in this section, "Improper Benefit" refers to:

- Medical assistance benefits provided pursuant to a TennCare rule, law, or regulation that the person is not entitled to receive or that are of a greater value than the person is authorized to receive;
- Benefits the person receives as a result of knowingly making a false statement or concealing a material fact relating to personal or household income that results in the assessment of a lower monthly premium than the person would

be required to pay if not for the false statement or concealment of a material fact; and Controlled substances benefits the person receives by knowingly, willfully and with the intent to deceive, failing to disclose to a health care provider that the person received the same or similar controlled substance from another practitioner within the previous 30 days and the person used TennCare to pay for either the clinical visit or for the controlled substance.

False Claims

An entity or person (but not an enrollee or applicant) commits a Class D felony who knowingly obtains or attempts to obtain, or aids or abets a person or entity to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, medical assistance payment under TennCare to which the entity or person is not entitled or which are of greater value than that to which the entity or person is entitled.

Misrepresentation of Medical Condition or Eligibility for Insurance.

An entity or person commits a Class D felony who by means of a willfully false statement regarding another person's medical condition or eligibility for insurance to aid the person in obtaining or attempting to obtain medical assistance payments, benefits or any assistance provided under TennCare to which the person is not entitled, or which are of greater value than that to which the person is authorized to receive. ("Attempting to obtain" as used in this section includes knowingly making a false claim.)

Obstruction of Investigation.

Any entity or person commits a Class D felony who in connection with any of the above offenses knowingly and willfully falsifies, conceals or omits by any trick, scheme, artifice, or device a material fact; makes a materially false or fraudulent statement or representation; or makes or uses a materially false writing or document.

Criminal Penalties, Restitution, and Sanctions.

- Criminal felony penalties as described above;
- Restitution to TennCare of the greater of the total amount of all medical assistance payments made to all providers, or a managed care entity, related to the services underlying the offense;
- Disqualify the person from participation in TennCare; and
- Report the person or entity to the appropriate professional licensure board or Department of Commerce and Insurance for disciplinary action.

4. Requirements for Reporting Fraud and Abuse

Persons who have knowledge of fraud and abuse are required to report it as follows:

- **Recipient, Enrollee or Applicant Fraud.** Providers, managed care organizations, and others must notify the Office of TennCare Inspector General immediately when there is actual knowledge of TennCare recipient, enrollee or applicant fraud. Call toll-free 1-800-433-3982 or go online to www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. This obligation does not apply if the knowledge is subject to a testimonial privilege.
- **Provider Fraud.** Providers, managed care organizations, and others must notify the Medicaid Fraud Control Unit immediately when there is actual knowledge of provider fraud. Call toll-free 1-800-433-5454.
- **Failure to Report.** Any person who willfully fails to report fraud shall be subject to a civil penalty of up to \$10,000 for each finding of the TennCare Inspector General.

BCPTN will comply with the reporting requirements established by The Centers for Medicare and Medicaid Services (CMS).

5. Education of Employees, Contractors, and Agents

Deficit Reduction Act of 2005

If provider receives or makes annual Medicaid payments of \$5 million or more, they meet the definition of a “covered entity” under section 6032 of the Deficit Reduction Act of 2005 and shall provide information/education to employees, contractors and agents of the provider about false claims recovery including the following components:

1. Provide detailed information in written policies applicable to employees, contractors, and agents of the provider about the federal False Claims Act and any State laws that pertain to civil or criminal penalties for making false claims and statements to the Government or its agents.
2. Provide detailed information about whistleblower protections under such laws, along with the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.
3. These written policies must also include detailed information about the provider’s policies and procedures for detecting and preventing fraud, waste, and abuse.
4. The provider’s employee handbook, if the “covered entity” has one, shall include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the provider’s policies and procedures for detecting and preventing fraud, waste and abuse.
5. The provider shall have documented instructions on how to report suspected fraud including the telephone number and person to contact within the organization. These instructions shall also tell how to report suspected fraud to external agencies such as the State of Tennessee Comptroller’s hot-line **(1-800-232-5454)**, the Tennessee Department of Finance and Administration’s Office of Inspector General (OIG) fraud and abuse hot-line (1-800-433-3982) and the Tennessee Bureau of Investigation (TBI) Medicaid fraud hot-line **(1-800-433-5454)**.
6. The provider shall have procedures to follow up on suspected fraud including how they report the results of their investigation.

6. Non-Discrimination

BCPTN participating Providers through their contracts with us and in compliance with existing federal and state laws, rules and regulations agree not to discriminate against members in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

C. Coordination of Benefits, Medicare Secondary Payer and Third Party Liability

BCPTN includes the provision for Coordination of Benefits (COB), which applies when a member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary payer prior to submission to BCPTN.

All Medicare secondary payer rules apply. These rules can be found in the *Medicare Secondary Payer Manual* located at www.cms.gov/Manuals/IOM/list.asp also at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

Providers should identify primary coverage and provide information to BCPTN at the time of billing.

BCPTN does not pay for services when a third party is required to be the primary payer. This section only covers collections related to the BCPTN program and its responsibility to;

- Identify payers that are primary to BlueCare Plus Tennessee BCPTN

- Identify the amounts payable by those payers
- Coordinate its benefits to members with the benefits of the primary payers

In some circumstances, a secondary payer status may arise from settlements and other insurance plans. In some cases, coverage for a BCPTN member may depend on the following;

- Whether the enrollee entitlement to Medicare is due to age or disability;
- Who is the primary beneficiary of the other insurance plan; or
- The size (number of employees) of the sponsoring employer group.

BCPTN may be secondary if the member is 65 years or older and is covered by a Group Health Plan (GHP) as a result of;

- Current employment or
- Employment of a spouse of any age and;
- The employer employs 20 or more employees

When a BCPTN member is disabled, and the member is covered by a Large Group Health Plan (LGHP) because of either:

- Current employment or
- A family member's current employment
- The employer employs 100 or more members

The purpose of Coordination of Benefits (COB) is to avoid duplicate payments for covered services. COB is applied when the member is also eligible for other health insurance. Providers should submit claims for payment to the primary plan first. Any amount payable by BCPTN is governed by the amount paid by the primary plan. Follow the guidelines below for correct billing;

- When BCPTN is primary, submit the claim directly to BCPTN
- When BCPTN is secondary, submit to the primary carrier first. Attach the Explanation of Benefits (EOB) with the claim then submit to BCPTN. The policy# listed on the member's identification card should be submitted on the EOB. If the correct policy# is not filed, the claim will be denied. A corrected bill will need to be submitted.
- When a service is non-covered by BCPTN and the member is eligible with Medicaid, submit the claim with the BCPTN EOB to the Member's assigned MCO. Effective 1/1/2026, for members enrolled in a FIDE plan, submit the claim directly to BCPTN. When a member's Part A benefits are exhausted, the MCO will require a copy of the Part A and Part B EOBs in order to determine appropriate reimbursement. Effective 1/1/2026, As of 1/1/26, when a member's Part A benefits are exhausted and they are enrolled in a FIDE plan, BCPTN will process the Medicare and Medicaid benefits.

Providers generally request additional insurance information from patients at the point of service. Providers should bill the primary payer first. If the probable existence of other insurance exists for a particular member, as determined by BCPTN, then BCPTN may deny and return claims to the provider, with the instruction that the provider should bill the third party payer first. When denying a claim for other insurance, BCPTN must give the provider other insurance data in order that the provider can appropriately submit the claim to the third party or primary payer.

In some situations, the availability of other insurance may not be identified until the provider claim has been processed and adjudicated. The other insurance can be identified by internal or external sources.

- Providers always have the discretion to refund payments they have received from BCPTN or one of its contractors, in order to pursue payment from the primary

insurance. Once a provider has refunded a payment received from BCPTN or one of its contractors, the provider may not resubmit another claim to BCPTN or its contractor for the same service furnished to the same enrollee on the same date.

- This policy is not intended to affect the ability of BCPTN to recover a duplicate payment when both BCPTN and a third party have paid a claim to the same provider for the same service. If BCPTN learns of the availability of primary insurance after it has made payment to the provider, then BCPTN may recover its payment to the provider if all of the following conditions are met.
 - Less than nine months have passed since the date of service when there is a commercial insurer or Medicare involved;
 - Prior to recoupment of its payment, BCPTN notified the provider with a refund request letter that included, at a minimum:
 - Identification of BlueCare Plus Tennessee BCPTN payment;
 - The name of the provider;
 - The list of claims or a reference to a remittance advice date;
 - The reason for overpayment (Example: “Another commercial insurance carrier was the primary carrier at the time of service”);
 - The identification and contact information of the insurance carrier who was determined to have been primary at the time of service, together with information about the insurance policy so that the provider can bill the insurance carrier;
 - A time period of at least forty-five (45) calendar days in which the provider may return the BCPTN payment and/or appeal the decision;
 - Information about how and where to file an appeal with BCPTN and
 - A request that the provider submit claims to the other insurance if not already done.

When providers choose to appeal the refund request letter from BCPTN, they are given sixty (60) calendar days in addition to the thirty (30) initial calendar days stated in the letter to provide sufficient documentation to BCPTN prior to the BCPTN's recovery of their payment. Providers should include a copy of a denial from the primary carrier in their appeal, if available.

BCPTN has ensured that there is a separate Service Line or Prompt for provider inquiries regarding these recoveries.

BCPTN may not recoup payments made to a provider when COB is discovered unless all of the above criteria have been met. All appeals should be submitted to the address listed below:

BlueCare Plus Tennessee
Provider Appeals Ste 0039
1 Cameron Hill Circle
Chattanooga, TN 37402

The Centers for Medicare & Medicaid Services does require that sufficient data will be shared between BCPTN and the state to allow for the coordination and/or integration of Medicare and Medicaid benefits.

III. Member Enrollment

BCPTN offers enrollment under three products: BlueCare Plus, BlueCare Plus Choice and BlueCare Plus Select. BCPTN enrollment is limited to people that are both Medicare and Medicaid eligible with specific diseases or conditions. All plans tailor the members' benefits, provider choices and drug formularies (list of covered drugs) to best meet the specific needs of members, in this complex population.

All plans under BCPTN are available for individuals that have Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Medicaid. Eligibility for BlueCare Plus Choice requires enrollment in Medicaid Choices 1, 2, or 3. Effective DOS 1/1/2026, BlueCare Plus Choice requires individuals be enrolled in Choices 1, 2, or 3 or in Employment and Community First Choices (ECF). All plans include physical and behavioral health services and prescription drug coverages as well as coordination of all healthcare services for the member.

If an individual joins BlueCare Plus the following is applicable:

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage
- Receives standard Medicaid benefits through their assigned Medicaid MCO BCPTN will provide coordination for Medicaid services and coverage.
 - Effective DOS 1/1/2026, members enrolled in BlueCare MCO will receive standard Medicaid benefits directly through BlueCare Plus.
- Receives Medicare prescription drug coverage
- Additional supplemental benefits are provided

If an individual joins the BlueCare Plus Choice the following is applicable:

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage
- Receives standard Medicaid benefits, including Medicaid Long Term Services and Supports (LTSS) through the Choices program
 - Effective DOS 1/1/2026, members enrolled in Employment and Community First Choices (ECF) with the BlueCare MCO will also receive their Medicaid benefits through BlueCare Plus Choice.
- Receives Medicare prescription drug coverage
- Additional supplemental benefits are provided

If an individual joins BlueCare Plus Select the following is applicable:

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage
- Receives standard Medicaid benefits through their assigned Medicaid MCO except for:
 - Members in the BlueCare MCO
 - 1915(c) waiver members
 - QMB only

In these cases, BCPTN will coordinate Medicaid services and coverage. .
- Receives Medicare prescription drug coverage
- Additional supplemental benefits are provided

Beneficiaries can enroll in BCPTN through;

- Online Enrollment Center <http://bluecare.bcbst.com>

- Calling Sales at 1-888-413-9637

Default Enrollment

Default Enrollment permits organizations that offer both a Medicare Advantage (D-SNP) plan and a Medicaid program (BlueCare/TennCare *Select*) to seamlessly convert individuals who become Medicare eligible. The individuals who are currently enrolled in BlueCare/TennCare *Select* and are about to become eligible for Medicare (based on age or disability) will receive a letter from the Division of TennCare and BCPTN explaining that they will automatically be enrolled in a BCPTN plan due to now being eligible for Medicare. These members will automatically be enrolled in one of our plans unless the beneficiary chooses to opt out.

A non-qualifying individual that disenrolls from BCPTN may re-enroll if the individual once again meets the specific qualifying characteristic(s) of BCPTN.

A. Summary of Benefits

State	Physician Services	Hospital and Ancillary Services
Tennessee	Bill TennCare MCO for cost sharing	Bill TennCare MCO for cost sharing

The member's assigned TennCare MCO is obligated to pay for Medicare deductibles, copayments and coinsurance for Medicare beneficiaries classified as QMBs and SLMB Plus and other dual eligible recipients. TennCare MCO is not required to pay Medicare coinsurance for non-covered services for SLMB Plus and other dual eligible recipients unless the enrollee is a child under age 21 or an SSI beneficiary. Cost-sharing obligations do not include:

- Medicare premiums that TennCare is required to pay under the State Plan on behalf of dual eligible members
- Payments for any Medicaid services that are covered solely by TennCare
- Any cost sharing for a Part D prescription drug

BlueCare network providers are required to refer dual-eligible members who are Quality Medicare Beneficiary (QMB) Plus or other Full Benefit Dual Eligible recipients to the members' TennCare managed care organization for the provision of TennCare benefits that are not covered by the BlueCare Plus or BlueCare Plus Select plan.

TennCare offers a broad array of long-term services and supports designed to help meet members unique needs. Long-Term Services & Supports (LTSS) is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness, physical disability and intellectual disability who cannot care for themselves for long periods of time. It is common for long-term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often-multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. Long-term services or supports may be needed by people of any age, even though it is a common need for senior citizens.

The Tennessee's CHOICES program provides the elderly (65 years of age and older) & adults with physical disabilities (21 years of age and older) who are eligible for TennCare with needed long-term services and supports in the home/community setting or nursing home.

TennCare offers the Employment and Community First CHOICES (ECF CHOICES) program, a managed, long-term services and support initiative that provides home and community-based

services to eligible individuals with intellectual and developmental disabilities. The program is designed to promote competitive employment and integrated community living. Information about the TennCare Managed Care Organization and available TennCare Program Benefits can be found at the following TennCare Program web sites:

<https://www.tn.gov/tenncare/providers.html>

<https://www.tn.gov/tenncare/members-applicants.html>

<https://www.tn.gov/tenncare/long-term-services-supports.html>

Providers should refer to the Division of TennCare Medicare and Medicaid Crossover Claims directions outlined on the Division of TennCare web site at:

<https://www.tn.gov/tenncare/providers/claims-appeals-provider-complaints/medicare-medicaid-crossover-claims.html>.

2026 BCPTN Benefits	
Description	Member Cost Sharing
Premium	\$0
OOP Maximum The OOP Max is only accumulated when the member actually pays cost sharing	\$9,350
Inpatient Hospital Coverage	Requires prior authorization \$0
Inpatient Mental Health Care	Requires prior authorization \$0
Skilled Nursing Facility	Requires prior authorization \$0 for 100 days per benefit period
Home Health Care Part-time or intermittent skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. Includes Physical therapy, occupational therapy, and speech therapy (Authorization Rules May Apply)	Zero Cost Sharing
Hospice	Medicare-certified hospice program is paid for by Original Medicare. BCPTN pays for a consultative visit prior to hospice.
Doctor Office Visits Routine or Specialist	Zero Cost Sharing

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- *BluePerks -** Created exclusively for BlueCross BlueShield of Tennessee members, BluePerks features discounts of up to 50 percent on a wide variety of alternative medical procedures – such as massage therapy, acupuncture and more. Plus, BluePerks also includes savings on health and wellness services, such as fitness centers, spas, personal trainers, Tai Chi classes and vitamins.
- **Silver&Fit -** A basic fitness center membership at a participating location near you with access to the basic amenities; Custom designed, low impact classes designed to improve your body’s strength and flexibility; On-site advisors to act as your contact for information and personalized service; and social events.
- ***Teladoc -** This is a valuable resource for BCPTN patients that have non-emergency health service questions or concerns. Members will speak with board-certified doctors by phone or video anytime, anywhere for urgent care conditions such as allergies, colds, fever, flu, or sinus or respiratory issues, cough, sore throat, nausea, rashes, insect bites and more. Services are available 24/7 and callbacks can be requested from first available doctor or schedule a visit. The number to call is 1-888-283-6691. Should a member have a serious health concern, such as chest pain, they should call 911.

B. Member ID Cards



BCPTN members should receive an Identification card (ID) prior to the effective date. However, if a member does not receive the ID card you can access member eligibility information on the BCPTN Website at bluecareplus.bcbst.com or contacting the BCPTN customer service line at 1-800-332-5762.


Presentation of the ID card does not guarantee eligibility. The card is for identification purposes only. Eligibility should be verified at the time services are received. The process of verifying eligibility is essential to avoid the following circumstances:

- Member may no longer be eligible
- Benefits may be altered
- Fraudulent use may occur

BlueCare Plus Member ID Card



This BlueCare Plus Member ID card may be used for Medicare, Medicaid and pharmacy benefits.


		BlueCare Plus
CHRIS B HALL Subscriber ID: ABCD12345678		MEDICAL/DENTAL/VISION Medicare Contract # H3259-001
Group No. 129884		Copayments: Office Visit \$0 Specialist Visit \$0 Hospital Stay \$0
RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840		

		bluecareplus.bcbst.com Member Service: 1-800-332-5762 Provider Line: 1-800-299-1407
Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior authorization required for admissions and other selected medical services. Report all emergency admissions within one working day.		Dental Member Services: 1-866-238-2627 Dental Provider Services: 1-866-238-2630 TTY/TDD: 711
This card is for identification, not for proof of eligibility.		Prior Authorizations: 1-866-789-6314 Pharmacists: 1-866-693-4620 Clinical Vendor Prior Authorization: 1-800-424-4871 (Required for: Advanced Radiological Imaging and Part B Meds) Vision: EyeMed 1-888-581-3648
Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002		CMS-H3259 749 (08/25)

BlueCare Plus Select Member ID Card



This card is used for Medicare and pharmacy benefits. If the member is eligible for Medicaid, claims must be submitted using the member's Medicaid card.


		BlueCare Plus Select
CHRIS B HALL Subscriber ID: ABCD12345678		MEDICAL/DENTAL/VISION Medicare Contract # H3259-003
Group No. 129884		Copayments: Office Visit \$0 Specialist Visit \$0 Hospital Stay \$0
RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840		

		bluecareplus.bcbst.com Member Service: 1-800-332-5762 Provider Line: 1-800-299-1407
Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior Authorization is required for admissions and other selected medical services. Report all emergency admissions within one working day.		Dental Member Services: 1-866-238-2627 Dental Provider Services: 1-866-238-2630 TTY/TDD: 711
This card is for identification, not for proof of eligibility.		Prior Authorizations: 1-866-789-6314 Pharmacists: 1-866-693-4620 Clinical Vendor Prior Authorization: 1-800-424-4871 (Required for: Advanced Radiological Imaging and Part B Meds) Vision: EyeMed 1-888-581-3648
Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002		CMS-H3259 753 (08/25)

BlueCare Plus Choice Member ID Card

This BlueCare Plus Choice Member ID card may be used for Medicare, Medicaid and pharmacy benefits.

		BlueCare Plus Choice
CHRIS B HALL Subscriber ID: ABCD12345678		MEDICAL/VISION Medicare Contract # H3259-002
Group No. 129884		Copayments: Office Visit \$0 Specialist Visit \$0 Hospital Stay \$0
RXBIN 004336 RXPCN MEDDADV RXGRP RX76AD Issuer 80840		

		bluecareplus.bcbst.com Member Service: 1-800-332-5762 Provider Line: 1-800-299-1407
Members: Present this card anytime you receive health care services. Members have limited or no benefits except when receiving services from a BlueCare Plus Network Provider. Providers: Submit claims to your local BlueCross BlueShield Plan, not original Medicare. Prior Authorization is required for admissions and other selected medical services. Report all emergency admissions within one working day.		TTY/TDD Line: 711 Prior Authorization: 1-866-789-6314 Pharmacists: 1-866-693-4620 Clinical Vendor Prior Authorization: 1-800-424-4871 (Required for: Advanced Radiological Imaging and Part B Meds) Vision: EyeMed 1-888-581-3648
This card is for identification, not for proof of eligibility.		
Submit Claims to: BlueCare Plus Operations 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002		CMS-H3259 720 (08/25)

C. Primary Care Provider (PCP)

PCPs are responsible for the overall health care of BCPTN members assigned to them.

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Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all medically necessary and covered services;
- Initiating and/or authorizing referrals for specialty care;
- Collaboration with the care coordinator and the Interdisciplinary Care Team (ICT);
- Monitoring the continuity of member care services;
- Routine office visits for new and established members;
- Counseling and risk intervention, family planning
- Immunizations and other preventive services
- Administering and interpreting a member’s health needs assessment results;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance (\$1,000,000 individual and \$3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

BCPTN PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of BCPTN members. In return for the additional efforts in caring for BCPTN members, PCPs receive a higher reimbursement rate for participation in the Model of Care (MOC) Training and Interdisciplinary Care Team (ICT).

The Membership Listings are available electronically via Availity. If you have not registered for Availity, visit www.bcbst.com. If you need assistance, contact our eBusiness Service Center at 423-535-5717 (option 2) or email Ecomm_TechSupport@bcbst.com.

There are four report selections available:

- Added Members Since Last Report
 - Lists information about newly assigned members reflected on the current listing. These members should not be listed on any previous membership listings for the provider.
- Current Members
 - Lists information about members assigned to the provider on the previous membership listing
- Members Transferred from Provider
 - Lists information about members transferred to another PCP or MCO
- Dropped Members
 - Lists information about members who have either changed MCOs or are no longer eligible for TennCare

The legend below describes fields on the PCP Membership Listing:

Field	Description
Date	Date the member listing report was created
Pay To	Address where the PCP’s payment was sent
Member Name	Member last name, first name and middle initial

Effective with PCP	Date member assigned to PCP. The names are listed alphabetically, last name first.
Member Address	Address of assigned member
DOB/Sex/SSN	Date of birth, gender of assigned member and his/her Social Security Number
ID Number/Old Member	New identification number, old Social Security Number
Effective Date of Coverage	Date the member became eligible for BCPTN
Future Disenroll Date	Date member will be disenrolled from the BCPTN program. This date will change if the Division of TennCare notifies us of eligibility status change
Effective with PCP	Date member became effective with PCP

The Primary Care Provider change is considered initiated when:

- A member calls in a PCP change request to BCPTN Customer Service line;
- A member mails in a written PCP change request to BCPTN Plus Customer Service
- Provider or provider's designated staff change a member's PCP assignment using the BlueCare Plus PCP Maintenance Application located in Availity, the secure area on the company websites: <http://bluecareplus.bcbst.com> and www.bcbst.com
- PCP change requests are made effective on the date of the request.
- Miscellaneous PCP Assignment Information
- When a member requests a new PCP, the member must fall within the PCP's stated patient accept criteria
- If a PCP wants to change his/her patient acceptance criteria, he/she must submit a written request to the Provider Management Department. This request can be submitted on a Primary Care Provider Change Form or on the PCP's letterhead and mail to:

BlueCare Plus Tennessee

Fax to BlueCare Plus PCP Department

1 Cameron Hill, Circle Ste 0002

Attention: PCP Change Team

Chattanooga, TN 37402-9025

1-888-309-7093

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IV. Provider Requirements

A. Provider Networks

Participation in BlueCross BlueShield of Tennessee/Volunteer State Health Plan, dba BCPTN Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BCBST/BCPTN Provider Networks or needing to communicate any changes in their practice should review the contact list located at <https://provider.bcbst.com/contact-us/my-contact> and contact their local Provider Network Manager.

Providers can access a copy of their contract in DocuSign and/or the Availity Document Viewer or initiate a request for a copy of their own contract by calling our Provider Service line at 1-800-924-7141. Say “Contracts” when prompted.

If you’re an individual practitioner joining a group practice that’s already contracted with us, first you must be eligible to participate in all the networks in which the group is contracted.

You’ll need a valid and current CAQH profile. Next, you’ll enroll for Electronic Funds Transfer (EFT) with Change Healthcare. If your group practice participates in our BlueCare and TennCare*Select* networks, you’ll also need a Medicaid ID from TennCare before applying with us.

Having all of these items complete at the time you submit your online application through Availity ensures we have what we need to process your enrollment timely and smoothly and allows you to fill out only one application with us for all networks in which your group participates.

If you or your patients may submit a claim to us, but you aren’t currently interested in network participation, we recommend you register with us by filling out an Out of Network Provider Form located in Availity in the BCBST Payer Space. The purpose of registering with us is to identify key information about you and ensure accurate distribution of payments, remittance advices (Explanation of Payments), and 1099 forms. This registration in no way signifies that you participate in any of our networks.

1. Network Participation Criteria

BlueCross BlueShield of Tennessee has established network participation criteria detailing the terms and conditions for participation in our provider networks. These terms and conditions will be consistently applied to all providers regardless of participation status.

Our network participation criteria is governed by the Provider Participation Status Committee (PPSC), which evaluates and oversees provider participation and takes appropriate actions that aren’t quality of care issues. Quality of Care issues are governed by the Clinical Risk Management Committee and the Credentialing Committee.

Network participation criteria apply to any provider who:

- is a network provider; as defined in the applicable provider network participation agreement with the Plan
- is recruited by the Plan;
- requests participation or re-applies for participation;

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- re-applies following voluntary or involuntary termination of provider's participation;
- has a significant change in practice, or
- has other intervening event or activity, which initiates a re-application and/or reconsideration of the provider's current participation status.

Note: Specific specialty participation requirements for practitioners, institutions and ancillary providers can be found within Credentialing section, and are in addition to and supplement, where applicable, these network participation criteria.

The following are our minimum network participation criteria:

- I. **Provider must have a physical practice location or be employed by a group practice that has a physical practice location in Tennessee or Catoosa, Dade, or Walker counties in Georgia.**
- II. **Must have a state medical license that is current, valid and unrestricted.**
 - If the provider's medical license has been revoked, suspended or not renewed (a license "revocation") by any jurisdiction, for cause, or the provider has surrendered or agreed to surrender license to avoid such a revocation, the provider will be considered for participation at a minimum of one year after the date that provider's license was reinstated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a provider, their participation shall not be considered unless the charges are dismissed or otherwise, and their license is maintained.
- III. Malpractice insurance – minimum \$1 million/\$3 million – unless a State of Tennessee employee
- IV. Accept all terms of the contract between BCBST/BCPTN and the practitioner.
- V. Ability to pass all credentialing requirements as indicated in Credentialing section.
- VI. Successfully pass site evaluation for PCP & High Volume Specialist – see Credentialing section for Site Visit tool.
- VII. Admitting privileges or an appropriate arrangement as defined by Credentialing with a BCBST/BCPTN Network Hospital – exceptions must be approved by Credentialing Committee.
- VIII. Availability Standards – network participation is dependent on the business needs of BCBST/BCPTN and its affiliates.

Member Access Standards

- Agrees to provide care to members within BCBST/BCPTN standards.
- Demonstrates a practice history, which BCBST/BCPTN deems consistent and comparable with the provider's ability to comply with these standards.
- Seven-day; 24 hours coverage through participating providers required

Medical:

Routine exam, preventive care, physical exam:

- Adult: Annual, within a year of the last scheduled physical after coverage becomes effective or if the last physical is greater than one year, within three months. For routine care less than or equal to 15 business days from date of the request for regular or routine appointments.
- Children: Less than or equal to 15 business days from date of the request - According to the American Academy of Pediatrics periodicity schedule.

- Prenatal care: To be seen in the first trimester, in less than or equal to six weeks of patient's suspected pregnancy. If the first appointment is beyond the first trimester less than or equal to 15 weeks after onset of pregnancy.

Urgent care for adult & child:

- Less than or equal to 48 hours

Emergency care for adult & child:

- Immediate evaluation by an appropriate provider-refer to facility-based provider

Specialty care for adult & child:

- Less than or equal to 30 days
- As practitioner deems appropriate for condition or follow-up

Wait times:

- Office wait time (including lab and X-ray): less than or equal to 45 minutes
- Member phone call during office hours:
 - Routine: less than or equal to 24 hours
 - Urgent: less than or equal to 15 minutes
- For afterhours phone calls where the member leaves a message with an answering service/machine, the provider or their designated call coverage provider (unless otherwise approved by BlueCross, the call coverage provider shall be a BlueCross participating provider) will return the phone call to the member within the following time frames:
 - In less than or equal to 30 minutes from when the member calls and leaves a message for urgent calls, and
 - In less than or equal to 90 minutes from when the member calls and leaves a message for routine calls

Seven days; 24 hour coverage through participating providers required for all networks. BCBST/BCPTN may ensure compliance by calling provider's offices after hours to see if return phone calls are received within the above time frames.

IX. Reimbursement

- Agrees to the price and reimbursement schedule for the network.
- Agrees to the reimbursement methodology.
- Agrees to not balance bill members for covered services.
- Delegation – subject to minimum criteria as established and approved by Delegate Oversight Committee.
- Administrative Services Only (ASO) available.
- Acceptance of Electronic Funds Transfer (EFT).
- Electronic Claims Submission.
- **Quality Improvement/Utilization Review/Medical Management Program**
- Cooperate with BCBST/BCPTN Quality Improvement (QI) and Utilization Management (UM) programs.
- Maintain a QI/UM plan.
- Demonstrate practice style and history, which BCBST/BCPTN deems consistent and comparable with BCBST/BCPTN quality management program standards and practices.

- Meet BCBST/BCPTN acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.

X. General Provisions:

- Meet Member satisfaction standards – based on member complaints, grievances, and satisfaction survey(s).
- Demonstrate willingness to cooperate with other providers, hospitals, and health care facilities.
- Agree to participate in exclusive arrangements that are required or negotiated.
- Satisfactory record on fraud and abuse and billing practices.
- Practice style, which is consistent with current standards of medical delivery.
- Prescribing pattern, which is consistent with BCBST's/BCPTN's quality management program.
- If the Provider's DEA certification, Controlled Dangerous Substances Certificate or any schedules have been revoked suspended or not renewed (a "revocation") by any jurisdiction for cause, or surrendered to avoid imposition of such revocation, provider won't be considered for participation for a minimum of one year after the date that provider was re-issued a certificate or schedule except as otherwise provided by applicable law. If a certificate or schedule revocation action is pending or initiated against a provider, the provider's participation won't be considered unless the charges are dismissed or otherwise resolved such that the provider retains certification or schedules.
- Abide by the terms of our Provider Dispute Resolution Procedure.
- If a provider has established an adversarial relationship with BCBST/BCPTN, members, or participating providers that might reasonably prevent the provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's/BCPTN's agreements with that provider, other providers, members or other parties, provider may not be considered for initial or continued participation in BCBST/BCPTN networks.
 - Such adversarial relationships may include, but are not limited to:
 - Credible evidence of making defamatory statements about BCBST/BCPTN;
 - Initiating legal or administrative actions against BCBST/BCPTN in bad faith; BCBST's/BCPTN's pending or termination of the provider's participation agreement for cause; and
 - Prior or pending collection actions against members in violation of an applicable hold harmless requirement.
 - This participation criteria is not intended to prevent the provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e., to "gag" the provider from discussing relevant matters with members).
 - Involving members or third parties in disputes with BCBST/BCPTN prior to receiving a final determination of that dispute in accordance with BCBST's/BCPTN's Provider Dispute Resolution Process may be deemed, however, to constitute an adversarial relationship with BCBST/BCPTN.
- Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process or failure to maintain hospital privileges at a network hospital. For administrative terminations, the provider may reapply when the deficiency is resolved.
- Provider or its owner/board member or managing partner has not:

- Been indicted;
- Been convicted of a crime;
- Committed fraud; or
- Been accused or convicted of any offense involving moral turpitude in any jurisdiction.
- Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), of CMS Preclusion List.

➤ Term of Contract:

- Annual: August 1
- Dental: 30 day clause

Additional criteria for Institutional Providers:

- I. Medicare Certification Requirements - Refer to Credentialing section
- II. Accreditation Requirements - Refer to Credentialing section.
- III. Hospitals contracted in counties, contiguous to our exclusive service area, must meet the minimum criteria to justify BCPTN network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis.

Providers not meeting any of these criteria may be immediately terminated from the BCBST/BCPTN networks or BCBST/BCPTN may refuse participation in any BCBST/BCPTN networks. In either event and unless otherwise specified in the termination notice, the provider may not be considered, at the discretion of BCBST/BCPTN for participation for a minimum of two years after the date of the failed requirement, except as otherwise provided by applicable laws. In the event of an arrest, a provider's initial or continued participation may not be considered, at the discretion of BCBST/BCPTN, unless the charges are dismissed or otherwise resolved in the provider's favor.

Note: Individual providers must participate in all networks for the contracted group they are joining except where participation in one or more of the contracted group's networks would be prohibited by law for such individual provider.

2. Changes in Practice

Certain federal and state regulations may require BCBST/BCPTN contracted providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice, please refer to the following:

- Updates for individual practitioner profiles, must be made on the Council for Affordable Quality Healthcare (CAQH) website at CAQH® ProView Profile. Updates to information not collected at CAQH® for practitioners, that are more specific to BCBST/BCPTN, can be submitted through the online Change Request application within the BCBST Payer Space in Availity at this link: [Update Network Information](#)
- Updates for group, facility, and ancillary providers are through the online Change Request application within the BCBST Payer Space in Availity at this link: [Update Network Information](#)
- Questions regarding changes to provider profile can be sent to us at Contracts_Reqs@bcbst.com

- Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure provider directories utilized by members contain the most current and correct information about your practice

We require individual practitioners to update and/or attest to their information in CAQH within 90 days of the notification to validate their data information. For facilities and ancillary providers, we require the return of every data verification form (DVF) received (even if there are no updates) every quarter. Depending on specialty and practice location, some providers may receive multiple attestation requests; providers must attest to each request for verification they receive. If an attestation isn't made in CAQH within a timely manner or if a DVF isn't signed, dated, and returned every quarter, the provider may be removed from our provider directory until they update and/or attest that their information is accurate. Removal from the directory won't impact network participation or claim processing. Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure provider directories used by members contain the most current and correct information about your practice.

The following changes may require reconsideration for continued participation of a currently contracted provider, immediate termination of a contracted provider, review of the initial application by a non-contracted provider, or re-application for participation by a non-contracted provider.

BCBST and BCPTN reserve the right to interpret and apply these criteria in its sole discretion and judgment.

Any provider adversely affected by BCBST/BCPTN's application of these criteria will be entitled to the appropriate appeals procedure set forth in the Provider Dispute Resolution Procedure or in this Manual. In the event of a change of ownership mentioned below, the provider is required to adhere to the change of ownership policy in Attachment I.

Changes to Practitioner

Practitioners must timely report to BCBST/BCPTN any changes in their practice, including but not limited to:

- Change in practice locations
- Change in practice specialty
- Changes in tax or group NPI
- A particular practitioner entering into or exiting from a group practice
- Change in ownership
- Change in hospital privileges
- Change in insurance coverage
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, State Children Health Insurance Program etc.) or peer review committee
- Malpractice claim(s) and/or judgment(s)
- Indictment, arrest, conviction or moral turpitude allegation
- Adversarial relationship with BCBST/BCPTN
- Any material change, which affects the practitioner's ability to perform its obligations to members and/or BCBST/BCPTN; and
- Any material change to in the information submitted to CAQH or on our application for network participation

Changes to Institutional, Ancillary Providers or Group Practice

Institutions, ancillary providers, and group practices must timely report to us any changes to their practice, including but not limited to:

- Change in ownership or control, including a change to or addition of a tax identification number or NPI
- Malpractice claim(s) and/or judgment(s)
- Change in insurance coverage
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all providers to maintain a license
- Adversarial relationship with BCBST/BCPTN
- Any material change which affects the organization's ability to perform its obligations to member(s) and/or BCBST/BCPTN
- Any material change in the information submitted on BCBST/BCPTN application for network participation

Additionally, in the event of a change of ownership, providers are required to adhere to the change of ownership policy in Attachment II.

We reserve the right to interpret and apply these criteria in our sole discretion and judgment. Any provider adversely affected by our application of these criteria will be entitled to the appropriate appeals process set forth in the Provider Dispute Resolution Procedure section.

3. Providers Denied Participation

Providers denied participation in a BCBST/BCPTN Network for other than network need, may not reapply for a minimum of one year from the date of denial. Providers will be given reason for denial and notice when they may reapply to networks as determined by and at the Provider Participation Status Committees at its sole discretion.

This requirement may be waived by BCBST/BCPTN in its sole discretion.

4. Removal of Providers from BCBST/BCPTN Provider Network

The Provider Participation Status Committee (PPSC) will review and take action on requests for removal of providers from BCBST/BCPTN provider networks including, but not limited to, lack of minimum participation standards, no malpractice insurance, aberrant billing practice, pattern of out of network referrals, or providers that have been arrested or indicted, been convicted of a crime, committed fraud or been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons for immediate termination set forth in the Provider's Agreement. If PPSC determines a provider falls within any of these termination reasons, a provider may be immediately terminated from the BCBST/BCPTN Tennessee networks or BCBST/BCPTN Tennessee may refuse participation in any BCBST/BCPTN networks.

The PPSC may also address any breach of contract that can lead to terminating a network provider.

In the event of termination of a provider's network participation and unless specified in the termination notice, a provider may not be considered, at the discretion of BCBST/BCPTN, for network participation for a minimum of two (2) years after the date of the resolution of failed requirement, except as otherwise provided by applicable laws. In the event of an arrest or indictment, a provider's initial or continued participation may not be considered, at the

discretion of BCBST/BCPTN, unless the charges are dismissed or otherwise resolved in the provider's favor.

The PPSC delegated the responsibility for initiating administrative terminations to the Provider Network Operations (PNO) Department. If the PNO staff confirms all BCBST/BCPTN policies and procedures were followed related to such administrative terminations, notice of termination may be sent to a provider without PPSC review. If the PNO staff identifies unique circumstances that warrant a committee level review, the termination action may be brought to the PPSC. A list of delegated termination include, without limitation:

- Loss of License
- Loss of DEA Registration, if applicable
- Lack of appropriate malpractice/general liability insurance
- Medicare/Medicaid or SCHIP Sanctions
- Failure to submit all required information necessary to complete the BCBST/BCPTN credentialing or recredentialing process
- Loss of credentialing
- Lack of network specific admitting privileges (or provision of coverage by a participating Provider)
- Lack of network specific 24 hour coverage
- Retired/deceased/moved out of BCBST/BCPTN exclusive service area
- Excluded from participation in the Medicare/Medicaid and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101 or otherwise not in good standing with the Division of TennCare
- Debarred from receiving federal contract by the General Services Administration and listed on the System for Award Management (SAM) Database.
- Debarred or suspended by the Federal Employee Program/Postal Service Health Benefits Office of Personal Management (OPM)
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
- Inclusion on the CMS Opt-Out List
- Inclusion on the CMS Preclusion List
- Lack of valid NPI
- Deactivated NPI or no NPI
- Termination of Medicaid ID/participation by the Division of TennCare (if applicable)

A report will be submitted to the PPSC reflecting administrative terminations at least quarterly. Providers removed from a BCBST/BCPTN provider network may reapply in accordance with the network participation criteria or the timeframe set forth in the provider's termination notice.

If a provider is removed from all BCBST/BCPTN networks, their credentials will be suspended on the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

5. Provider Termination Appeal Process

Providers whose network participation has been terminated pursuant to the terms of their contract may be entitled to the procedural remedies set forth below (except as set forth in Quality Improvement Program section or Provider Dispute Resolutions Procedure section).

- All notices concerning Provider Network Management contract terminations with cause or without cause are communicated according to the provisions in the provider's contract.

- Termination notices sent to providers will include instructions on appealing the termination decision.
- Providers (except as set forth in Paragraph 3 below) whose network participation has been terminated without cause may take any dispute concerning this termination to binding arbitration as set forth in section 1(c) below.

1. APPEAL OF WITH CAUSE TERMINATION OF A PARTICIPATING PROVIDER

a. Reconsideration

- i. The Provider may request a reconsideration of BCBST's decision by submitting a request in writing within thirty (30) days of the date of the notice of termination to the provider. Failure to meet this requirement will result in a waiver of the right to appeal the termination. PPSC will send to provider a response to this request for reconsideration.

b. Appeal

- i. If the provider is not satisfied with BCBST's response to the provider's reconsideration request, the provider may request an appeal by telephonic hearing. The provider must request in writing a telephonic hearing no later than fourteen (14) days of BCBST's decision on the provider's request for reconsideration. Failure to meet this requirement will result in a waiver of the right to a telephonic hearing.
- ii. Following receipt of a written request for a telephonic hearing from a provider pursuant to section 1.b.i, BCBST will contact the provider to establish a mutually acceptable date and time for the telephonic hearing, which generally shall be conducted within the thirty (30) day period following receipt of the written request. If the provider fails to appear at the hearing without good cause, the right to schedule another hearing is forfeited.
- iii. For practitioners, telephonic hearings shall be conducted by a panel chosen by BCBST.
- iv. For Institutional and Ancillary Providers, telephonic hearings shall be conducted by a hearing officer chosen by BCBST.
- v. Formal rules of evidence or legal procedure will not be applicable during any telephonic hearing.
- vi. In addition to any procedure adopted by the Panel/Hearing Officer, for telephonic hearings:
 1. The provider has the right to be represented by an attorney or other representative. If the provider elects to be represented, such representation shall be at his or her own expense.
 2. The hearing may be recorded by a court reporter at BCBST's discretion.
 3. The provider and BCBST must provide the other party with a list of witnesses expected to testify on their respective behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
 4. Each party has the right to inspect and request copies of any documentary information that the other party intends to present during the hearing, at the inspecting party's expense upon reasonable advance notice.
 5. During the hearing, each party has the right to:
 - a. Call witnesses
 - b. Cross-examine opposing witnesses

6. Following the hearing, each party may obtain copies of any record of the hearing, upon payment of the charges for that record.
 - vii. The Panel/Hearing Officer will send BCBST and the provider a written response within sixty (60) days of the date of the telephonic hearing. The Panel's/Hearing Officer's decision will be reviewed by the PPSC and BCBST's final decision will be sent to the provider.
 - c. Binding Arbitration
 - i. If the provider is not satisfied with BCBST's final decision, the next and final step is binding arbitration. The provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XIV(B) – Provider Dispute Resolutions Procedure.
 2. APPEAL OF DENIAL OF APPLICATION OF AN APPLICANT
 - a. Written Appeal
 - i. A provider may appeal by submitting a written statement of his/her position within thirty (30) days of the notice of the denial of application. The written appeal will be reviewed by the PPSC. A written response will be sent to the provider within sixty (60) days of our receipt of the written appeal.
 - b. Binding Arbitration
 - i. If the provider is not satisfied with the PPSC's decision, the next and final step is binding arbitration. The provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XIV(B) – Provider Dispute Resolution Procedure.
 3. APPEAL OF TERMINATION BY A PARTICIPATING PHYSICIAN IN BCPTN NETWORKS
 - a. Physicians terminated with or without cause from BCBST's/BCPTN networks shall be afforded the procedural rights set forth in subsection 1 above.

6. Federal Exclusions Screening Requirements

The following definition apply for the purpose of the Exclusion Screening Requirements:

➤ Exclusion Lists

The U.S. Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's (GSA) System for Award Management (SAM), the Social Security Death Master File ("DMF") and TennCare's Terminated Providers List.

➤ Ineligible Persons

- Any individual or entity who:
 - Is excluded, debarred, suspended or otherwise ineligible to participate in federal healthcare programs or in federal procurement or non-procurement programs (as of the date such Exclusion Lists are accessed by the provider); or
 - Has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their obligation to screen all employees and contractors ("Exclusion Screening Process") against the Exclusion Lists. They also need to conduct criminal background checks and registry checks and exclusion checks in accordance with state law to determine whether any employee, agents and contractors have been determined to be Ineligible Persons (making them excluded from participation in the Medicare or Medicaid programs). At a minimum, registry and exclusion checks must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee

Sexual Offender Registry, TennCare Terminated Provider List and the Social Security Death Master File. The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and monthly thereafter. Providers are also required to have employees and contractors disclose whether they are Ineligible Persons prior to providing any services on behalf of the Provider. The Exclusion Screening Process is a Centers for Medicare & Medicaid Services (CMS) requirement and a condition of provider's enrollment as a BCBST/BCPTN Provider and is also a continuing obligation during their contractual term.

Providers and their subcontractors must comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening. Provider entities that bill and/or receive federal funds agreement must screen their owners, board member, agents, and employees against the Exclusion Lists. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits must be refunded to and/or recouped by BCBST/BCPTN.

BCBST/BCPTN providers must immediately report any exclusion information discovered. (See Introduction section for a listing of appropriate contact numbers.)

If a provider determines that an owner, board member, employee or contractor is an Ineligible Person, the provider will need to take the appropriate action to remove the owner, board member, employee or contractor from responsibility for, or involvement with the provider's operations related to federal healthcare programs. In such event, the provider must take all appropriate actions to ensure that the responsibilities of such owner, board member, employee or contractor have not and will not adversely affect the quality of care rendered to any BCBST/BCPTN member of any federal health care program.

EXCLUDED PROVIDER

If BCBST/BCPTN discovers that a provider has been excluded, precluded or debarred, BCBST/BCPTN will remove the provider from all BCBST Medicare, Medicaid participating networks in accordance with the administrative termination provisions in Section 4.

EXCLUDED PRACTITIONER IN A GROUP

If BCBST/BCPTN discovers a practitioner who is owner of a group practice is excluded, precluded or debarred. BCBST/BCPTN will remove the group from all BCBST Medicare and Medicaid participating networks in accordance with the administrative termination provisions in Section 4.

If BCBST/BCPTN discover a practitioner who is part of a group practice is excluded, precluded, or debarred, BCBST/BCPTN will remove that practitioner from all BCBST participating networks in accordance with the administrative termination provisions in Section 4.

A provider may present documentation to support that the practitioner was not hired or affiliated with them on or after the exclusion effective date for BCBST/BCPTN to adjust the claims recovery period. In addition to the supporting documentation, an attestation form must be obtained from BCBST/BCPTN to indicate the dates that practitioner was employed by or associated with the provider. The supporting documentation and attestation must be received within 30 days of the date of the BCBST/BCPTN termination notice.

EXCLUDED OWNER, BOARD MEMBER, OR EMPLOYEE

If BCBST/BCPTN discovers that an owner, board member, or employee of a provider has been excluded, BCBST/BCPTN will remove the provider from all Medicare and Medicaid participating networks in accordance with the administrative termination provisions in Section 4.

A provider may present documentation to support that the owner, board member, or employee was not hired or affiliated with them on or after the exclusion effective for BCBST/BCPTN to adjust the claims recovery period. In addition to the supporting documentation, an attestation form must be obtained from BCBST/BCPTN to indicate the dates that the owner, board member, employee or contractor was employed by or associated with the provider. The supporting documentation and attestation must be received within 30 days of the date of the termination notice.

RECOUPMENT OF CLAIMS PAID TO OR FOR THE BENEFIT OF EXCLUDED PROVIDERS

If a provider or group is removed from our participating networks under this section as an excluded provider, we'll reprocess claims for all dates of service after the exclusion effective date. Some plans or products prohibit payment to excluded providers;

If the excluded provider is the owner of a group, claims for the group are not eligible for payment, and BlueCross will recover any payments for these plans or products previously made to the group during the exclusion period.

7. Subcontracting

Prior Approval

- Providers and Vendors who participate in the BlueCare, BlueCare Plus Tennessee and TennCareSelect networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior approval, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoupment.
- BlueCare Providers and Vendors shall submit the BlueCare Subcontract Request Form along with the signed Exhibit: EXHIBIT [X] DOWNSTREAM/SUBCONTRACTING PROVIDER COMPLIANCE WITH REQUIREMENTS OF BLUECARE TENNESSEE PROVIDER AGREEMENT located on BCBST.com to request approval of all subcontracts.

The subcontractor Request Form is located at the following link:

[Forms | Providers | BlueCare Tennessee \(bcbst.com\)](https://www.bcbst.com/forms/providers/bluecare-tennessee)

BlueCare Providers will submit these requests to [TennCare Provider Subcontracts@bcbst.com](mailto:TennCare_Provider_Subcontracts@bcbst.com)

BlueCare Vendors will submit these requests to [Vendor Relations_GM@bcbst.com](mailto: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) includes the Social Security Master Death File (MDF) and the System for Award Management (SAM) databases. The results of the screenings should be documented.

Records Retention

Records related to all subcontract agreements should be maintained for a minimum of ten (10) years after your agreement with BlueCare Tennessee expires and/or follow the language outlined in your vendor contract.

8. Interoperability Standards and HITECH Act

Providers are encouraged to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with Public Law 115-5, The Health Information Technology for Economic and Clinical Health (HITECH) Act

9. Provider Rights and Responsibilities

BCPTN Network Providers have a right to:

- Receive information about the managed care organization, its services, and its members' rights and responsibilities
- Be treated with respect and recognition of their dignity and right to privacy
- Require that members follow the plans and instructions for care that they have agreed upon with their Providers
- Be involved in the adoption of clinical practice guidelines
- Discontinue treatment of a member with whom the provider feels he/she cannot establish or maintain a professional relationship in accordance with the Contractor Risk Agreement
- Specify the functions and/or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional/technical practice
- Be paid upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.g. of the Contractor Risk Agreement

BCPTN Network Providers have the responsibility to:

- Recognize and abide by all applicable state and federal laws, regulations, and guidelines
- Assist in such reviews including the provision of complete copies of medical records
- Provide members and their representatives with access to their medical records
- Treat Member with respect and recognition of their dignity and right to privacy
- Allow Member participation in decision-making regarding their health care
- Discuss Medically Appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage
- Provide, to the extent possible, information that the managed care organization needs in order to provide quality care and service to members
- Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service
- Serve as a conduit to the Practitioner community regarding the dissemination of quality and other health care information
- Abide by the accessibility and availability standards as set forth in the Physician Contract or Agreement
- Provide Covered Services on 24-hour-a-day, 7-days-a-week basis with call coverage through Network BCPTN Practitioners
- Be capable of providing comprehensive health care services, in accordance with the network adequacy criteria for time/distance/patient volume, to their BCPTN members. Comprehensive services shall include, but not be limited to:
 - Preventive health services
 - Primary care services

- Home health care services
 - Practitioner services
 - Hospital services, including emergency services
- Be responsible for supervising or coordinating the provision of initial and primary care to members; for initiating specialty care; and for monitoring the continuity of Member care services.

B. Provider Credentialing

1. Introduction

The BlueCross BlueShield of Tennessee/BlueCare Tennessee Credentialing Program was established Aug. 1, 1995. The Credentialing Program is designed around goals that reflect the BCBST/BlueCare mission, as well as regulatory and accrediting requirements.

To ensure consistent standards for network participation and compliance with regulatory requirements, we have established the **Network Participation Criteria**.

- **Individual practitioners** seeking network participation must complete an application through the **Council for Affordable Quality Healthcare (CAQH)**. CAQH Solutions provides a centralized platform that streamlines the submission of provider information.
- In addition, all providers are required to submit a **Provider Enrollment Form** via **Availity**.
- **Organizational Providers** are required to submit a completed facility application provided by BlueCross BlueShield of Tennessee.

Using the submitted CAQH or facility application, we conduct a **preliminary evaluation** to determine eligibility for network participation. All applicants must:

- Complete the application in full
- Submit all required documentation
- Successfully complete the credentialing process

Credentialing must be finalized before network participation can begin.

Verifying credentials of practitioners and organizational providers is an essential component of an integrated health care system. The credentialing process includes a continuous evaluation of the quality of care provided by individual practitioners, and organizational providers seeking participation in our networks. Major components of the credentialing program include:

- Credentialing Committee
- Policies and procedures
- Initial credentialing process
- Recredentialing process
- Delegated credentialing activities

The Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee conducts peer review of cases meeting the exception criteria of the Credentialing and Recredentialing of Practitioners policy (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, make case-by-case decisions regarding the credentialing or continued credentialing of practitioners or organizations that meet exception criteria. While

some may be approved under these criteria, others may be denied or have their credentials terminated, based on the Committee's evaluation. Each case is individually assessed to determine whether credentialing aligns with the best interests of BlueCross BlueShield of Tennessee and its members. The Committee may also choose to deny credentialing to practitioners or organizations within a specific exception category if it determines that doing so is necessary to protect the health and welfare of our members. (Credentialing Committee Discretion Policy).

Practitioners and organizational providers have the right to:

- **Review** information submitted with their credentialing or recredentialing application, excluding peer-review protected materials.
- **Request** corrections to any erroneous information within **30 calendar days** of receipt of the completed application. Requests should be submitted via the contact methods listed below.
- **Inquire about the status** of their credentialing or recredentialing application at any time.

For questions or concerns regarding the credentialing process or specific applications, please contact:

BlueCross BlueShield of Tennessee – Credentialing Department

Toll-Free Phone: 1-800-924-7141

Fax: 1-423-535-8357

Alternate Fax: 1-423-535-6711

Email: Credentials@bcbst.com

Note: For information regarding denial or appeal rights, please refer to the **Medical Management Corrective Action Plan** in **Section X.(D)** of the **Quality Improvement Program** section of this Manual.

2. Credentialing Application

Credentialing applications are used to consistently collect key information from all practitioners and organizational providers seeking to join our networks.

Our credentialing standards apply to all licensed independent practitioners and organizational providers who maintain a direct contractual relationship with us.

The Credentialing Program evaluates whether these individual practitioners and organizational providers—licensed by the state and contracted with us and are qualified to deliver services and meet the minimum standards set by:

The National Committee for Quality Assurance (NCQA)

The Centers for Medicare & Medicaid Services (CMS)

The TennCare Risk Agreement

Verifying all required credentials is a critical part of this process to ensure quality and compliance.

Once practitioners and organizational providers have completed the credentialing process, they'll receive written notification within 10 days from our Credentialing Department.

Note: This notification doesn't guarantee acceptance in our networks; practitioners and organizational providers are not considered participating in our networks until they receive an acceptance letter from our Contracting Department. C.

Credentialing Policies

Please note that credentialing policies are subject to change. Final decisions regarding credentialing status are made by the **Credentialing Committee**.

For questions regarding credentialing or if assistance is needed, providers may contact their **Provider Representative** by visiting our Contact Us page at <https://provider.bcbst.com/contact-us/my-contact>

Alternatively, Customer Service may be reached directly at 1-800-924-7141.

Credentialing Process for Practitioner: (Medical and Behavioral Health)

BlueCross obtains practitioner data for the credentialing process from **CAQH**. Practitioners are required to complete their CAQH profile fully and accurately, and accurately and must attest to the information within **120 calendar days** prior to submitting their application for participation in a BlueCross network.

Additionally, practitioners must submit an **online enrollment form through Availity** to request, add, or update a specialty. For more details, refer to the section titled **Provider Networks**.

As part of the credentialing process, BlueCross will verify all required information based on the data attested to in the CAQH application. Any exceptions to the standard or additional criteria will be reviewed and determined by the **Committee**.

Base practitioner credentialing criteria (section references are to the CAQH application):

- **Section 1, Personal Information and Professional IDs**
- Personal Email Contact. Ensure the personal email contact is correct (we use this contact only if there is no response using the Section 3 contact)
- Drug Enforcement Administration (DEA). BlueCross requires a current, valid, and unrestricted DEA with all schedules
- License. BlueCross requires a current, valid, full, and unrestricted license to practice as a healthcare professional in the state(s) where services will be rendered.
- **Section 2, Education and Training**
- Education and training. BlueCross will use the provided education and training to determine specialty eligibility.
- **Section 3, Professional/Medical Specialty Information**
- Board Certification, if applicable. BlueCross will use the provided board certification information to determine specialty eligibility.

- Certification. Certifications for nurse practitioners and physician assistants should be listed in this section. BlueCross requires submission of a copy of the ANCC or AANP certificate.
- Primary Credentialing Contact. BlueCross will use this contact for all credentialing correspondence, regardless of what is submitted on the enrollment form.
- **Section 4, Practice Location Information**
- Current practice location. BlueCross will use this information to determine where the practitioner is currently practicing.
- Call Coverage. BlueCross requires 24-hour, seven-day-a-week call coverage or arrangements with a BlueCross credentialed or contracted practitioner or hospitalist group. Please note this is indicated on the CAQH application as 'Covering Colleagues'
- **Section 5, Hospital Affiliations**
- Hospital Privileges. BlueCross requires unrestricted hospital privileges.
- Admitting arrangements. BlueCross requires admitting arrangements to be with a BlueCross credentialed practitioner or hospitalist group.
- **Section 6, Professional Liability Insurance Carrier**
- Certificate of Insurance. BlueCross requires malpractice coverage in amounts of not less than \$1,000,000 per occurrence and \$3,000,000 aggregate (exceptions made for state employees).
- **Section 7, Work History and References**
- Work History. BlueCross requires work history for the last five years with documented gaps in employment over six months.
- **Section 8, Disclosure Questions**
- Disclosure questions. BlueCross requires an answer to all 26 disclosure questions. A detailed explanation of any question(s) answered "Yes" on the application will be required.

Some practitioner specialties may require specific licenses, certifications, or education. Others might be exempt from certain basic base requirements. These differences are listed below. If a specialty isn't listed, the general base requirements above apply:

Acupuncturist

- **Licensed as an Acupuncturist**
- Certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Audiologist:

- **Licensed as an Audiologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Behavior Analyst (CBA)

- **Licensed in the State of Tennessee as a Behavior Analyst**
- Practitioner must be a Board-Certified Behavior Analyst-Doctoral (BCBA D) by the Behavior Analyst Certification Board (BACB)
- DEA certificate isn't required

- Call coverage isn't required
- Hospital privileges aren't required

Certified Anesthesiologist Assistant (CAA or AA)

- Licensed as an Anesthesiologist Assistant in Tennessee
- DEA Certificate isn't required.
- Hospital privileges aren't required

Certified Registered Nurse Anesthetist (CRNA):

- Licensed as a Registered Nurse and an Advance Practice Nurse with qualifications listed as Nurse Anesthetist
- DEA Certificate isn't required
- Hospital privileges aren't required

Chiropractor:

- **Licensed as a Chiropractor**
- Hospital privileges aren't required
- Call coverage can be answering machine, cell phone, answering service or another provider
- DEA certificate isn't required

Chiropractor performing Acupuncture

- If the state license has acupuncture listed at the bottom, the practitioner has met the state's educational requirements to perform acupuncture

Dentist – Dental Anesthesiology:

- **Licensed as a Dentist (DDS or DMD):**
- Completion of residency in Dental Anesthesia or Board certification from the American Dental Board of Anesthesiology (ADBA)

Dentist – Endodontics; Periodontist; Prosthodontics:

- **Licensed as a Dentist**
- Hospital privileges aren't required

Dentist – General

- **Licensed as a Dentist**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist - Oral & Maxillofacial Surgeon (DDS, or DMD)

- **Licensed as a Dentist (DDS or DMD)**
- Completion of residency in Oral and Maxillofacial Surgery or ABOMS board certification

Dentist - Orthodontics:

- **Licensed as a Dentist- must list specialty of Orthodontics and Dentofacial Orthopedics**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist - Pediatric Dentist

- **Licensed as a Dentist**
- Completion of residency or license must list the specialty of Pediatric Dentist

- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dermatology

- **Licensed as a MD or DO with specialty of Dermatology**
- Hospital privileges are required for Micrographic Surgery (MOHS). If practitioner doesn't have their own privileges, an admitting arrangement or hospital group is acceptable

Dietitian/Nutritionist:

- **Licensed as a Dietitian/Nutritionist**
- Accreditation from the Commission on Dietetic Registration (CDR)
- Call coverage isn't required
- DEA certificate isn't required
- Hospital privileges aren't required

Genetic Counselors

- State licensed or certified at the highest level of independent practice in the state where practice is to occur.
- Hospital privileges aren't required
- 24/7 call coverage or arrangements. Answering machine/cell phone is acceptable.
- DEA certificate isn't required

Hospice & Palliative Care Practitioner

- **Licensed as a MD or DO**
- Hospital privileges aren't required
- **Call coverage not required**

Lactation Specialist

- **Licensed as a BCBST recognized specialty**
- Certification with IBCLC: Global Certification for Lactation Consultant
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Licensed Clinical Social Worker (LCSW)

- **Licensed as a Clinical Social Worker**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another practitioner in a behavioral health specialty
- Hospital privileges aren't required

Licensed Senior Psychological Examiner (LSPE):

- **State licensed or certified at the highest level of independent practice in the state where practice occurs**
- Hospital privileges aren't required
- 24/7 call coverage or arrangements. Answering machine/cell phone is acceptable
- DEA certificate isn't required

Marriage and Family Therapist

- **Licensed as a licensed Marriage and Family Therapist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another practitioner in a behavioral health specialty

- Hospital privileges aren't required

Nurse Practitioners or Nurse Mid-Wife:

- **Registered Nurse (RN) License**
- **Advanced Practice Nurse (APN) certificate in Tennessee and applicable prescriptive authority for contiguous states**
- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required

Nurse Practitioner – Master's Clinical Nurse Specialist/Psychiatric Nurse

- **RN License - May be from any state if it says multi-state**
- **Advanced Practice Nurse (APN) certificate in TN (Must have an active NP license in each state that they practice**
- Certification by American Nurses Credentialing Center as Nurse Practitioner - Psychiatric / Mental Health is required
- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required

Occupational Therapist

- Licensed as an Occupational Therapist
- DEA certificate isn't required
- Call coverage isn't required.
- Hospital privileges aren't required.

Optometrist:

- **State license must contain Therapeutic Certification**
- Hospital privileges aren't required
- DEA certificate isn't required
- Call coverage isn't required

Pathologist

- **Licensed as a MD or DO with the specialty listed as Pathologist**
- Hospital privileges aren't required
- DEA certificate isn't required
- Call coverage isn't required

Pharmacist - (Clinical, Immunizing, or Disease Management):

- **Licensed as a Pharmacist**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Physical Therapist:

- **Licensed as a Physical Therapist**
- Call coverage isn't required
- Hospital privileges aren't required
- DEA certificate isn't required

Physician Assistant:

- **Licensed as a Physician Assistant**

- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required

Physician Assistant - Surgical Assist:

- Licensed as a Physician Assistant
- National Commission on Certification of Physician Assistants NCCPA certification is required
- DEA certificate isn't required
- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.

Podiatrist

- **Licensed as a Podiatrist**
- Hospital privileges aren't required

Podiatrist – Foot and Ankle Surgery

- **Licensed as a Podiatrist**
- Hospital privileges are required - Admitting arrangement with a BCBST credentialed and/or contracted provider or hospitalist group is acceptable

Professional Counselors

(Includes, Addiction Counselors, Alcohol and Drug Counselors, Mental Health Counselors)

- **State licensed or certified at the highest level of independent practice in the state where practice occurs**
- Hospital privileges aren't required
- 24/7 call coverage or arrangements. Answering machine/cell phone is acceptable
- DEA certificate isn't required

Psychologists, Clinical or Clinical Child & Adolescent Psychologists (includes Psychologist and Psychoanalyst)

- **Licensed as a Psychologist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Psychologists –Tele-Health Provider with a PSYPACT license

- **Practitioner must have a PSYPACT license**
- **Practitioner must be licensed as a Psychologist in the APIT Home State listed on the PSYPACT license**
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university
- DEA certificate isn't required
- 24/7 call coverage or arrangements – Answering machine/cell phone is acceptable
- Hospital privileges aren't required

Radiologist Diagnostic

- **Licensed as a MD or DO with the specialty listed as Radiologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Radiology - Interventional

- **Licensed as a MD or DO with the specialty listed as Radiologist**
- Hospital privileges are required - Practitioner must have his/her own privileges

Sleep Medicine

- **Must be licensed as a MD or DO**
- Education and or board certification in Sleep Medicine required

Speech Language Pathologist or Speech Therapist

- **Licensed as a Speech Language Pathologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Surgery, General

- **Licensed as a MD or DO**
- Education and/or board certification in Surgery Hospital privileges are required.
- Hospital privileges are required - **Practitioner must have his/her own admitting privileges**

1. Credentialing Process for Medical and Behavioral Health Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensuring decisions are based on the most accurate, current information available. The following types of medical and behavioral health organizational providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

Organizational providers must be recredentialed every 36 months to meet federal and state regulatory guidelines.

The following information is required and/or must be verified for organizational providers:

- **Licensed in the State of Tennessee.** Providers receive a new license each year and it's considered proof of compliance; therefore, no site visit is required.
- Professional liability coverage of \$1,000,000 per case/ \$3,000,000 aggregate.
- Malpractice claims history for past five (5) years. NPDB reports or self-reported.
- Accreditation by: AAAASF (QUAD A), AAAHC/URAC, AAPM, AASM, ABCOP, ACHC, AOA, CABC, CARF, CHAP, CIHQ, COA, CORF, CUC, DNV-GL, HFAP, HQAA, National Association of Boards of Pharmacy, NBAOS, SAMHSA, UCAOA / CAUCQ, or The Joint Commission (TJC), If not accredited, State or Federal review in lieu of a site visit in the last 3 years.
- Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
- DEA certificate, if applicable.
- History of federal and/or state sanctions
- An attestation to the correctness and completion of the application

Acute Care Facility Hospital

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, AAAHC, CIHQ, or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site review in the last 3 years

Ambulatory Infusion Center (AIC)

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, AAAHC, CIHQ or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site visit in the last 3 years

Ambulatory Surgical Facility

- **Licensed as an Ambulatory Surgery Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, AAAASF (QUAD A), or CIHQ certification

Applied Behavior Analysis (ABA)

Note: Services will be provided at an Outpatient Mental Health Clinic level of intensity.

- **Licensed as a Mental Health Outpatient Facility**
- Must receive oversight from a licensed behavioral health or Behavior Analyst Certification Board (BACB) certified professional

Birthing Centers

- **Licensed as Birthing Center in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, or CIHQ certification required

Community Mental Health Center

- **Licensed as a Mental Health Outpatient Facility**

Crisis Stabilization Unit

- **Licensed as a Crisis Stabilization Unit**
- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by, CARF or COA or accredits the program itself as an observation/holding bed program that provides psychiatric services
- Accreditation isn't required

Dialysis Facility

- **State of Tennessee End Stage Renal Diseases (ESRD) Facility License**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate

Durable Medical Equipment (DME) Providers

- **Licensed as a DME provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- DEA certificate, if applicable
- Pharmacy License, if applicable
- TJC, CHAP, AAAHC, BOC, The Compliance Team, ABC, NBAOC, CARF, CIHQ, HQAA or ACHC required

Health Department

- **License isn't required**
- State Tort Insurance
- CLIA Certificate

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Home Infusion Therapy Providers

- **TN: Licensed as a Pharmacy License**
- Other States: Licensed according to that state's licensing laws
- DEA certificate, if applicable
- Accreditation isn't required

Home Health Agency

- **Licensed as a Home Health provider in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Hospice Provider

- **Licensed as a Hospice provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Independent Lab

- **Licensed as a Laboratory in Tennessee – Labs located in Physician Office, Hospital, etc., are exempt from licensure requirements**
- Other States: Licensed according to that state's licensing laws
- Must have referral from a BCBST participating/network practitioner
- Accreditation isn't required
- CLIA certificate required

Inpatient Psychiatric/ Residential Psychiatric

- **Licensed as a Mental Health Residential Treatment Center**
- Accreditation isn't required
- DEA certificate isn't required

Inpatient Substance Abuse Disorder

- **Licensed as an Alcohol and Drug Residential Treatment Center**
- DEA certificate isn't required
- Accreditation isn't required

Inpatient Rehabilitation Facility

- **Licensed as an Inpatient Rehabilitation Facility in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- DEA certificate, if applicable
- TJC, CARF, or CIHQ accreditation required (no exceptions)

Intensive Outpatient (Psychiatric)

- **Licensed as a Mental Health Outpatient Facility**
- DEA certificate isn't required
- Must provide services at least three (3) hours per day, at least two (2) days a week

Intensive Outpatient (Substance Abuse Disorder)

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- DEA certificate isn't required
- Must provide services at least three (3) hours per day, at least two (2) days a week

Non-Licensed DME Providers (Non-motorized equipment only e.g., walker canes, crutches)

- **License isn't required**
- DEA certificate isn't required
- Accreditation isn't required

On-Site Clinics

- State Business License
- Accreditation by Urgent Care Association of America (UCAOA) / Commission on Ambulatory and Urgent Care Quality (CAUCQ), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

Orthotic/Prosthetic Supplier

- **License isn't required**
- Board of Certification / Accreditation (BOC) is required

Opioid Treatment Program:

- **TN: Licensed as an Opioid Treatment Program (OTP) in Tennessee** Other States: Licensed in accordance with that state's licensing laws
- DEA certificate with all schedules is required
- CLIA certification, if applicable
- Certification by SAMHSA
- Must be accredited by, TJC, CARF, or COA

Outpatient Diagnostic Facility

- **Not licensed**
- CLIA certification, if applicable

Outpatient Mental Health Facility

- **Licensed as a Mental Health Outpatient Facility**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Substance Abuse Disorder Clinic

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Rehabilitation Facility

- **Not Licensed**
- Accreditation isn't required
- CLIA isn't required unless they have an onsite laboratory

Pain Management Center

- **TN: Licensed as an Ambulatory Surgical Facility**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate isn't required
- Must have CARF accreditation or American Academy of Pain Management accreditation

Partial Hospitalization (Psychiatric or Substance Use Disorder)

- **Licensed as a Mental Health Partial Hospitalization Facility**
- Accreditation isn't required
- DEA certificate isn't required

Professional Support Services Licensure (PSSL)

- **TN: Licensed as a Professional Support Service**

- Member of DDA (Department of Disability and Aging)

Psychiatric Hospital

- **TN: Licensed as a Mental Health Hospital Facility**
- Other States: licensed in accordance with the state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, CIHQ, AAAHC, or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site visit in the last 3 years

Psychosocial Rehabilitation Center

- **Licensed as a Mental Health Psychosocial Rehabilitation Center**
- Accreditation isn't required
- DEA certificate isn't required

Rural Health Clinics

- **Not licensed**
- State Tort insurance
- CLIA certification required
- Accreditation isn't required

Skilled Nursing Facility (No Swing Beds)

- **TN: Licensed as a Nursing Home**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA isn't required
- DEA certificate isn't required
- Accreditation isn't required – If not accredited, State or Federal review in lieu of a site visit in the last 3 years

Sleep Labs

- **Not licensed**
- Accreditation by American Academy of Sleep Medicine (AASM) or TJC or CIHQ required

Supportive Housing

- **Licensed as either a Supportive Living Facility or a Supportive Residential Facility**
- Assisted Care Living Facility (ACLF) Residential Facility, Mental Health Supportive Living Facility, or DDA license are acceptable
- Accreditation isn't required
- DEA certificate isn't required

Urgent Care Centers

- State Business License
- Accreditation or certification by Urgent Care Association of America (UCAOA), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

2. Recredentialing Process

All Medical or behavioral health practitioners will be recredentialled every 36 months.

In addition to the information that will be verified by primary or secondary sources, we'll include and consider collected information for the participating practitioner's performance within the

health plan, including information collected through the health plan's quality management program.

Recredentialing will begin approximately three to six months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and we'll retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the practitioner to visit the CAQH ProView™ website, <https://proview.caqh.org>, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that's subject to change must be re-verified from primary sources during the recredentialing process. The provider must attest to any limits on their ability to perform essential functions of the position and attest to absence of current illegal drug use.

3. Approved Specialties

We recognize and maintain the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Practitioners must designate a specialty on the credentialing application. To be listed in any of our provider directory in the specialty requested, the provider must meet one of the following requirements:

- Recognized board certification
- Practitioners: Successful completion of residency or fellowship in the applied specialty
- Other health care professionals: Licensure and additional certification, if applicable in the field of specialty
- Fellowship training will only be recognized for those specialties where there is not a residency program for the specialty. Completion of a fellowship program in a specialty for a limited time period will not be recognized if the applicant has not completed the full residency program for that specialty. Recognition of fellowship training will be made in the sole discretion of BCBST.

American Board of Medical Specialties (ABMS)

I. American Board of Allergy and Immunology

1. Allergy and Immunology

II. American Board of Anesthesiology

1. Adult Cardiac Anesthesiology
2. Anesthesiology
3. Critical Care Medicine
4. Health Care Administration, Leadership, and Management
5. Hospice and Palliative Medicine
6. Neurocritical Care

7. Pain Medicine
8. Pediatric Anesthesiology
9. Sleep Medicine
- III. American Board of Colon and Rectal Surgery**
 1. Colon and Rectal Surgery
- IV. American Board of Dermatology**
 1. Dermatopathology
 2. Micrographic Dermatologic Surgery
 3. Pediatric Dermatology
- V. American Board of Emergency Medicine**
 1. Anesthesiology Critical Care Medicine
 2. Emergency Medical Services
 3. Health Care Administration, Leadership, and Management
 4. Hospice and Palliative Medicine
 5. Internal Medicine – Critical Care Medicine
 6. Medical Toxicology
 7. Neurocritical Care
 8. Pain Medicine
 9. Pediatric Emergency Medicine
 10. Sports Medicine
 11. Undersea-Hyperbaric Medicine
- VI. American Board of Family Medicine**
 1. Adolescent Medicine
 2. Family Medicine
 3. Geriatric Medicine
 4. Health Care Administration, Leadership, and Management
 5. Hospice and Palliative Medicine
 6. Pain Medicine
 7. Sleep Medicine
 8. Sports Medicine
- VII. American Board of Internal Medicine**
 1. Adolescent Medicine
 2. Adult Congenital Heart Disease
 3. Advanced Heart Failure and Transplant Cardiology

4. Cardiovascular Disease
5. Clinical Cardiac Electrophysiology
6. Critical Care Medicine
7. Endocrinology, Diabetes, and Metabolism
8. Gastroenterology
9. Geriatric Medicine
10. Hematology
11. Hospice and Palliative Medicine
12. Infectious Disease
13. Internal Medicine
14. Interventional Cardiology
15. Medical Oncology
16. Nephrology
17. Neurocritical Care
18. Pulmonary Disease
19. Rheumatology
20. Sleep Medicine
21. Sports Medicine
22. Transplant Hepatology

VIII. American Board of Medical Genetics and Genomics, Inc.

1. Clinical Biochemical Genetics
2. Clinical Genetics and Genomics, (MD)
3. Laboratory Genetics and Genomics
4. Medical Biochemical Genetics
5. Molecular Genetic Pathology

IX. American Board of Neurological Surgery

1. Neurological Surgery
2. Neurocritical Care

X. American Board of Nuclear Medicine

1. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology

1. Complex Family Planning
2. Critical Care Medicine
3. Gynecologic Oncology

4. Gynecology
5. Maternal Fetal Medicine
6. Obstetrics
7. Obstetrics and Gynecology
8. Reproductive Endocrinology and Infertility
9. Urogynecology and Reconstructive Pelvic Surgery

XII. American Board of Ophthalmology

1. Ophthalmology

XIII. American Board of Orthopedic Surgery

1. Orthopedic Surgery
2. Orthopedic Sports Medicine
3. Surgery of the Hand

XIV. American Board of Otolaryngology – Head and Neck Surgery

1. Complex Pediatric Otolaryngology
2. Neurotology
3. Otolaryngology – Head and Neck Surgery
4. Plastic Surgery within the head and neck
5. Sleep Medicine

XV. American Board of Pathology

1. Pathology - Anatomic / Pathology - Clinical
2. Pathology - Anatomic
3. Pathology – Clinical
4. Blood Banking Transfusion Medicine
5. Clinical Informatics
6. Cytopathology
7. Dermatopathology
8. Hematopathology
9. Neuropathology
10. Pathology – Chemical
11. Pathology – Forensic
12. Pathology – Medical Microbiology
13. Pathology – Molecular Genetic
14. Pathology – Pediatric

XVI. American Board of Pediatrics

1. Adolescent Medicine
2. Child Abuse Pediatrics
3. Developmental-Behavioral Pediatrics
4. Hospice and Palliative Medicine
5. Medical Toxicology
6. Neonatal-Perinatal Medicine
7. Pediatrics
8. Pediatric Cardiology
9. Pediatric Critical Care Medicine
10. Pediatric Emergency Medicine
11. Pediatric Endocrinology
12. Pediatric Gastroenterology
13. Pediatric Hematology-Oncology
14. Pediatric Hospital Medicine
15. Pediatric Infectious Disease
16. Pediatric Nephrology
17. Pediatric Pulmonology
18. Pediatric Rheumatology
19. Pediatric Transplant Hepatology
20. Sleep Medicine
21. Sports Medicine

XVII. American Board of Physical Medicine and Rehabilitation

1. Brain Injury Medicine
2. Neuromuscular Medicine
3. Pain Management
4. Pediatric Rehabilitation Medicine
5. Physical Medicine and Rehabilitation
6. Spinal Cord Injury Medicine
7. Sports Medicine

XVIII. American Board of Plastic Surgery, Inc.

1. Plastic Surgery
2. Plastic Surgery within the head and neck
3. Surgery of the Hand

XIX. American Board of Preventive Medicine

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1. Aerospace Medicine
2. Addiction Medicine
3. Clinical Informatics
4. Health Care Administration, Leadership, and Management
5. Medical Toxicology
6. Occupational and Environmental Medicine
7. Public Health and General Preventive Medicine
8. Undersea and Hyperbaric Medicine

XX. American Board of Psychiatry and Neurology

1. Addiction Psychiatry
2. Brain Injury Medicine
3. Child And Adolescent Psychiatry
4. Clinical Neurophysiology
5. Consultation-Liaison Psychiatry
6. Epilepsy
7. Forensic Psychiatry
8. Geriatric Psychiatry
9. Neurocritical Care
10. Neurodevelopmental Disabilities
11. Neurology
12. Neurology with special qualification in Child Neurology
13. Neurodevelopmental Disabilities
14. Neuromuscular Medicine
15. Pain Management
16. Sleep Medicine
17. Vascular Neurology

XXI. American Board of Radiology

1. Diagnostic Radiology
2. Interventional Radiology and Diagnostic Radiology
3. Medical Physics (Diagnostic, Nuclear, Therapeutic)
4. Neuroradiology
5. Nuclear Radiology
6. Pain Medicine
7. Pediatric Radiology

8. Radiation Oncology

9. Radiology

XXII. American Board of Surgery

1. General Surgery

2. Complex General Surgical Oncology

3. Pediatric Surgery

4. Surgery

5. Surgery of the Hand

6. Surgical Critical Care

7. Vascular Surgery

XXIII. American Board of Thoracic Surgery

1. Thoracic and Cardiac Surgery

2. Congenital Cardiac Surgery

XXIV. American Board of Urology, Inc.

1. Urology

2. Pediatric Urology

3. Urogynecology and Reconstructive Pelvic Surgery

American Osteopathic Association Boards (AOA)

I. American Osteopathic Board of Anesthesiology

1. Anesthesiology

2. Critical Care Medicine

3. Pain Management

4. Pediatric Anesthesiology

II. American Osteopathic Board of Dermatology

1. Dermatology

2. Dermatopathology

3. MOHS-Micrographic Surgery

4. Pediatric Dermatology

III. American Osteopathic Board of Emergency Medicine

1. Emergency Medical Services

2. Emergency Medicine

3. Hospice and Palliative Medicine

4. Medical Toxicology

5. Sports Medicine

6. Undersea and Hyperbaric Medicine

IV. American Osteopathic Board of Family Practice

1. Addiction Medicine
2. Correctional Medicine
3. Hospice and Palliative Care Medicine
4. Family Medicine
5. Geriatric Medicine
6. Pain Medicine
7. Sports Medicine
8. Undersea & Hyperbaric Medicine

V. American Osteopathic Board of Internal Medicine

1. Addiction Medicine
2. Cardiology
3. Clinical Cardiac Electrophysiology
4. Correctional Medicine
5. Critical Care Medicine
6. Endocrinology
7. Gastroenterology
8. Geriatric Medicine
9. Hematology
10. Hematology/Oncology
11. Hospice and Palliative Care Medicine
12. Infectious Disease
13. Internal Medicine
14. Interventional Cardiology
15. Nephrology
16. Oncology
17. Pain Medicine
18. Pediatric and Adult Allergy & Immunology
19. Pulmonary Disease
20. Rheumatology
21. Sleep Medicine
22. Sports Medicine
23. Undersea and Hyperbaric Medicine

VI. American Osteopathic Board of Neurology and Psychiatry

1. Addiction Medicine
2. Child And Adolescent Neurology
3. Child And Adolescent Psychiatry
4. Geriatric Psychiatry
5. Hospice & Palliative Medicine
6. Neurology
7. Neurophysiology
8. Psychiatry
9. Sleep Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine

1. Neuromusculoskeletal Medicine
2. Osteopathic Manipulative Medicine
3. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine

1. In Vivo and In Vitro Nuclear Medicine
2. Nuclear Cardiology
3. Nuclear Imaging and Therapy
4. Nuclear Medicine

IX. American Osteopathic Board of Obstetrics and Gynecology

1. Female Pelvic Med/Reconstructive Surgery
2. Gynecologic Oncology
3. Gynecology
4. Maternal And Fetal Medicine
5. Obstetrics
6. Obstetrics And Gynecology
7. Reproductive Endocrinology & Infertility

X. American Osteopathic Board of Ophthalmology and Otolaryngology

1. Ophthalmology
2. Otolaryngology / Facial Plastic Surgery
3. Otolaryngic Allergy
4. Sleep Medicine

XI. American Osteopathic Board of Orthopedic Surgery

1. Orthopedic Surgery

2. Hand Surgery
3. Orthopedic Sports Medicine

XII. American Osteopathic Board of Pathology

1. Anatomic Pathology
2. Chemical Pathology / Laboratory Medicine
3. Dermatopathology
4. Forensic Pathology

XIII. American Osteopathic Board of Pediatrics

1. Neonatology
2. Pediatric Allergy and Immunology
3. Pediatrics
4. Sports Medicine

XIV. American Osteopathic Board of Physical Medicine & Rehabilitation

1. Physical Medicine & Rehabilitation
2. Hospice and Palliative Medicine
3. Pain Medicine
4. Sports Medicine

XV. American Osteopathic Board of Preventive Medicine

1. Aerospace Medicine
2. Correctional Medicine
3. Occupational Medicine
4. Public Health/ Community Medicine
5. Undersea and Hyperbaric Medicine

XVI. American Osteopathic Board of Proctology

1. Proctology

XVII. American Osteopathic Board of Radiology

1. Diagnostic Radiology
2. Neuroradiology
3. Pediatric Radiology
4. Radiation Oncology
5. Radiology
6. Vascular & Interventional Radiology

XVIII. American Osteopathic Board of Surgery

1. Cardiothoracic Surgery

2. General Surgery
3. Neurological Surgery
4. Plastic and Reconstructive Surgery
5. Surgery
6. Vascular Surgery
7. Surgical Critical Care
8. Urological Surgery

American Board of Dental Sleep Medicine

1. Dental Sleep Medicine

American Academy of Pediatrics (AAP)

1. Pediatric Heart Surgery
2. Pediatric Neurosurgery
3. Pediatric Orthopedics
4. Pediatric Urology

American Board of Oral and Maxillofacial Pathology

1. Oral Pathology

American Board of Oral and Maxillofacial Surgery

1. Oral and Maxillofacial Surgery
2. Oral Pathology

American Board of Orthodontics

1. Orthodontics

American Board of Pediatric Dentistry

1. Pediatric Dentistry

American Board of Periodontology

1. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric

1. Podiatry (DPM)

American Board of Podiatric Surgery

1. Podiatry (DPM)

American Board of Prosthodontics

1. Prosthodontics

American Chiropractic Neurology Board, Inc.

1. Chiropractic Neurology

Other Health Care Professionals:

- I. Acupuncturist
- II. Audiology
- III. Addictionologist (Non-Psychiatrist)
- IV. Associate Behavior Analyst
- V. Certified Behavior Analyst
- VI. Certified Registered Nurse Anesthetist (CRNA)
- VII. Chiropractor (DC)
- VIII. Chiropractor Neurologist
- IX. Dietitian
- X. Employee Assistance Professional Counselor
- XI. Endodontist
- XII. Family Practice with Obstetrical Fellowship
- XIII. General Dentistry
- XIV. General Practice
- XV. Licensed Clinical social Worker (LCSW)
- XVI. Licensed Professional Counselor
- XVII. Licensed Senior Psychological Examiner (LSPE)
- XVIII. Marriage and Family Therapist
- XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
- XX. Midwife (CNM)
- XXI. Neuropsychology (Ph.D.)
- XXII. Nurse (RN)
- XXIII. Nurse Clinician
- XXIV. Nurse Practitioner
- XXV. Nurse Practitioner, Acute Care
- XXVI. Nurse Practitioner, Adult Health
- XXVII. Nurse Practitioner, Family Practice
- XXVIII. Nurse Practitioner, Gerontology and Adult Health
- XXIX. Nurse Practitioner, Neonatal
- XXX. Nurse Practitioner, Pediatrics
- XXXI. Nurse Practitioner, Psychological/Mental Health
- XXXII. Nurse Practitioner, Women's Health
- XXXIII. Nutrition

- XXXIV. Occupational Therapy (OT)
- XXXV. Optometry
- XXXVI. Pastoral Counselor
- XXXVII. Pediatric Anesthesiology
- XXXVIII. Pediatric Genetics
- XXXIX. Pediatric Ophthalmology
- XL. Pediatric Plastic Surgery
- XLI. Pharmacist - Clinical
- XLII. Pharmacist – Immunizing
- XLIII. Physical Therapist (PT)
- XLIV. Physician Assistant (PA)
- XLV. Physician Assistant – Surgical Assist
- XLVI. Professional Counselor
- XLVII. Prosthetist/Orthotist
- XLVIII. Psychiatrist
- XLIX. Psychologist or Psychoanalyst Psychology (Ph.D.)
 - L. Speech Pathology/Speech Therapy (ST)
 - LI. Therapeutic Optometry

4. Accrediting Bodies We Recognize

- Accreditation Association for Ambulatory Health Care (AAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
– Now QUAD A
- American Association for Marriage and Family Therapy (AAMFT)
- American Association of Critical Care Nurses (AACN)
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABCOP)
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)

- American Speech-Language-Hearing Association (ASHA)
- Board of Certification / Accreditation (BOC)
- Certified Urgent Care Program (CUC)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Commission on Ambulatory and Urgent Care Quality (CAUCQ)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Division of TennCare or Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Healthcare Facilities Accreditation Program (HFAP)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- Pediatric Nursing Certification Board
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The Center for Improvement in Healthcare Quality (CIHQ)
- The Joint Commission (TJC)
- The Medical Quality Commission (TMQC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare
- Urgent Care Association of America (UCAOA)

Practice Site/Medical Record Standards

Practice Site Standards

BlueCross BlueShield of Tennessee/BCPTN has adopted practice site standards for all credentialed practitioners that provide ambulatory care to our members. These standards were developed to ensure members have access to care in a clean, safe, organized, and physically accessible environment.

Clinical Risk Management (CRM) will review all practitioner office site quality complaints/referrals to ensure practitioner offices meet these standards. Main sources for the Office Site Quality referrals may include member complaints, onsite auditors (e.g., credentialing, clinical quality assurance, internal audit) or other internal or external sources. Credentialed practitioners will be advised in

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writing about specific complaints received concerning the quality of the office site. Credentialed practitioners with two office quality complaints within a six-month period, including, but not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to the Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within 60 days of the second member complaint. CRM will investigate the severity of all complaints received. We may also act on only one complaint if determined necessary.

Primary care provider (PCP) practice sites and OB/GYN sites, not previously reviewed and currently occupied by a network practitioner, will be evaluated prior to or within 60 days of initial credentialing.

Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to the Clinical Risk Management Committee and re-audited within approximately six months. Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Practice Improvement Plan and a 2nd re-audit planned within approximately six months.

We have adopted the current established site review standards listed below. Compliance with all required elements noted with an asterisk (*) and an overall score of 80% is required to meet these site review standards.

These standards are subject to change, and revisions will be posted in quarterly updates.

*Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the practitioner on call. Review of after-hours coverage is documented by Clinical Quality Assurance on a separate tool.

Site Review Standards

1. *The office must be wheelchair accessible.
2. *The office must be clean and organized, with adequate exam room and waiting room space.
3. *The office must have adequate lighting in all patient areas such as the entryway, waiting room, restrooms, and treatment areas.
4. *Exam rooms must be designed for patient privacy.
5. There should be evidence of compliance with our appointment availability standards for routine and urgent care.
6. *There must be an individual medical record for each patient.
7. *Current medical records must be available at the site where services are provided and readily accessible.
8. *Medical records must be kept in a secure location. Sites with electronic medical records should provide evidence of a secure off-site record retention/recovery process.
9. *There must be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
10. *There must be evidence of a fire safety/emergency action plan with evidence of staff education. In locations with 10 or more employees, the plan must be documented in writing.
 - At a minimum, the fire safety/emergency plan should include:
 - Well-marked evacuation routes that are clear and unobstructed
 - Working fire extinguishers and smoke detectors
 - Compliance with local fire codes
11. *Emergency supplies and procedures must be available for scope of practice.

- At a minimum, the emergency supplies and procedure requirements should include:
 - Epinephrine and oxygen
 - Delivery kit in addition to epinephrine and oxygen for obstetrical sites and family practice sites who provide care for pregnancy.
 - Crash cart and oxygen at sites that perform stress tests or services that require sedation.
- 12. *The office must have infection control procedures that include appropriate disposal of bio-hazardous material. Hand washing facilities must be in/near treatment rooms and Occupational Safety and Health Administration (OSHA) standards and Material Safety Data Sheet (MSDS/SDS) information must be available to staff.
- 13. *There must be a process for the appropriate disposal of needles and other sharps.
- 14. There should be a process for inventory control of all stock and sample medications including evidence of regular monitoring of expiration dates.
- 15. *There must be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
- 16. *Controlled substances must be maintained in a locked area.
- 17. *Evidence of CLIA registration with a site-specific address is required for any practice where labs are performed.
- 18. *If radiology services are provided, a current state inspection compliance notice must be posted with the date of the last inspection.
- 19. Radiology techniques should be posted near the radiology equipment if not generated by radiology equipment.
- 20. There should be a sign posted that physician extenders may provide care, where applicable.
- 21. Professional staff should be licensed appropriately with evidence of licensure on file.
- 22. Member rights and responsibilities should be posted or otherwise made available to members.

Comprehensive Medical Record Standards

Network practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than 5% of credentialed primary care practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with the practitioner or practitioner representative if applicable. In addition, medical record reviews will be performed during the annual Healthcare Effectiveness Data and Information Set (HEDIS®) project and analysis performed to identify practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

Medical Record Keeping Practices

1. Medical records should be legible.
2. Member identification must be on each page of the record.
3. Each recorded chart entry must be dated and identified by the author. Stamped signatures aren't acceptable.
4. The medical records should be readily accessible to the practitioner during normal office hours.

Documentation

5. All medical records must contain a current member problem list, which addresses chronic and significant recurrent/acute conditions.
6. All medication allergies, absence of allergies, and/or adverse reactions must be consistently documented and prominently displayed in all medical records.
7. An initial history and physical exam should be documented for new patients within 12 months of the member first seeking care, or within three visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age six should be documented.
8. Each medical record must contain an updated list of medications the member is taking, or documentation that the member isn't currently taking any medications.
9. Each medical record must contain tobacco, alcohol, and/or substance use history (for members 12 years and over and seen three or more times).
10. The medical record of all members aged 18 years and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members.
11. If the member has executed an advance directive, a copy should be on file within the office.

Appropriateness of Care

12. Each visit should include documentation of member's chief complaint or purpose for the visit. Clinical assessment and a physical exam should be documented and correspond to the member's stated complaint or visit purpose and/or ongoing care for chronic illnesses.
13. Working diagnosis or medical impressions that logically follow from the clinical assessment and physical exam should be recorded.
14. Rationale for treatment decisions should be medically appropriate and substantiated by documentation in the record, with lab tests performed at appropriate intervals.
15. Records should substantiate the member's clinical problems and treatment so another practitioner can determine the member's overall clinical course under the reviewed practitioner's management.

Continuity and Coordination of Care

16. There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone calls or return office visits.
17. Medical records should contain documentation of appropriate use of consultants, which includes behavioral health providers, and documentation of medical services performed by a referral specialist/practitioner.
18. If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

Education and Preventive Care

19. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with *The U.S. Preventive Services Task Force Guide to Clinical Preventive Services*. or the *American Academy of Pediatrics*, as applicable.
20. Care for high-risk conditions should be documented in accordance with the Clinical Practice Guidelines (CPG's).
21. There should be documentation of member education/instructions.

Facility Site Standards

Non-accredited facilities applying for initial credentialing with BlueCross BlueShield of Tennessee/BCPTN networks must meet and maintain compliance with the site standards listed below.

Noncompliant sites for currently credentialed providers will be referred to the BlueCross BlueShield of Tennessee/BCPTN Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed providers until BlueCross BlueShield of Tennessee/BCPTN facility site standards are met.

Physical Assessment

1. The facility must be wheelchair accessible.
2. The facility should be clean and organized with adequate lighting throughout, and space in treatment rooms to conduct patient exams effectively.

After Hours Coverage

3. Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping

4. There should be an individual medical record for each member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

Safety

8. Emergency supplies and procedures should be available for the scope of practice.
9. Policies and procedures should be available and reviewed annually regarding administrative, operational, safety and disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management and infection control.
11. There should be infection control measures consistent with Occupational Safety and health Administration (OSHA) guidelines.
12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if labs are performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological techniques should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies with evidence of regular monitoring of expiration dates.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.

19. The facility should maintain equipment in a safe manner consistent with the manufacturer recommendations.
20. Member rights and responsibilities should be posted, or available in the facility.
21. Professional staff should be licensed appropriately, with evidence of licensure on file.
22. The facility should have a defined process to ensure professional performance of its staff by:
 - a. Completing the credentialing process for independent practitioners.
 - b. Completing credentialing functions according to state, federal and NCQA standards.
 - c. Using the current license, relevant training and experience, current competence, and privileges at a hospital in the credentialing process.
23. A credentialing representative will audit the facility's files to ensure the credentialing process meets the above criteria.

D. Electronic Data Interchange (EDI)

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically ensures compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. Additional information regarding electronic claims is available [here](#).

All network providers are required to receive payment by Electronic Funds Transfer (EFT) to remain in compliance with the terms of the Minimum Practitioner Network Participation Criteria. More information regarding Electronic Funds Transfer (EFT) is available [here](#).

BCPTN accepts claims electronically in the ANSI 837 format additional information is available [here](#).

BCBST accepts electronic funds transfer (EFT) enrollment through Change Healthcare who offers a universal enrollment tool for providers that provides a single of entry for adopting EFT and ERA. The Change Healthcare process facilitates compliance with CAQH Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

To view/print a copy of your remittance advices, ensure you have access to Availity, BCBST's secure area on its websites, www.bcbst.com and <https://bluecare.bcbst.com>.

For more information regarding the EFT program process, or for assistance with Availity, please call eBusiness Service at 800-924-7141 and follow the prompts to eBusiness support or email eBusiness_service@bcbst.com.

Payer Enrollment Services is the new name for the Change Healthcare EFT and ERA enrollment tool.

Phone: 800-956-5190 Monday through Friday, 8 a.m. to 5 p.m. (Central)

Website: payerenrollservices.com

Submission of professional charges are on the CMS-UB04/ANSI-837 Professional Transaction and institutional charges on the CMS-UB04 /ANSI-837 Institutional Transaction. Claims data should be complete and filed for all services both covered and non-covered. Billed services for the same patient, same date of service (DOS), same place of service (POS), must be billed on a single claim submission. Claims data is vital to report measurements and statistics needed for the Healthcare Effectiveness Data and Information Set (HEDIS) and URAC requirements.

The start date for determining the timely filing period is the date of service or “From” date on the claim. For institutional claims (Form CMS-1450, the UB-04 and now the 837I that includes span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness. For professional claims (Form CMS-1500 and 837P) submitted by physicians and other suppliers that include span dates of service, the line item “From” date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.)

BCPTN timely filing period is 1 year from the date of service or, for facilities, within 1 year from the date of discharge.

If the provider has documented evidence the member did not provide BCPTN insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the member’s benefit agreement.

The Health Care Claim Acknowledgement Report

The Health Care Claim Acknowledgement Report supplies providers with one comprehensive report of all claims received electronically. The provider should maintain this report for proof of timely filing. A provider submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox.

To learn more about retrieving your electronic reports, contact eBusiness Solutions at 423-535-5717, Monday through Thursday, 8 a.m. to 6:00 p.m. (ET) and Friday, 9 a.m. to 6:00 p.m. (ET).

Note: Submission dates of claims filed electronically that are not accepted by BCPTN due to transmission errors are not accepted as proof of timely filing.

1. Filing Electronic Claims

The electronic claims processing system used by BCPTN is in compliance with Federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS). This system is for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BCPTN business edits are modified to recognize the required ANSI formats. These edits apply to electronic claims.

Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:

Claims submitted electronically must include the provider’s appropriate individual BCPTN provider number and/or NPI in the required data elements as specified in the Implementation Guide. This guide is available online via the X12.org website at <https://x12.org/products>. You may access additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission at [Digital Resources for Providers | BCBS of Tennessee \(bcbst.com\)](https://www.bcbst.com).

Note: BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) guidelines for filing the National Provider Identifier (NPI) Number.

2. Electronic Enrollment and Support

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, provider number, NPI, name), or any changes of software vendor should be communicated to

eBusiness Solutions via the *Provider Electronic Profile* form. The provider Electronic Profile form is accessible through [Availity](#) or visit our website [here](#) for additional details.

For technical support or enrollment information, call, fax, or e-mail:

Technical Support call: 423-535-5717
E-mail: www.ecomm_support@bcbst.com

Enrollment call: 1-800-924-7141
Fax: 423-535-7523
E-mail: www.ecomm_contracts@bcbst.com

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCross BlueShield of Tennessee uses the ANSI 837 version. BlueCross BlueShield of Tennessee accepts the ANSI 837 version, 5010 formats. American National Standards Institute has accredited a group called "X12" that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

3. Secure File Gateway (SFG)

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. Submit claim files through SFG. How to use SFG can be found [here](#).

ANSI 837 (Version 5010)

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the [x12.org website here](http://x12.org). Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at [here](#) under Electronic Data Interchange.

*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company website at <http://www.wpc-edi.com>. Additional companion documents are available for BlueCross BlueShield of Tennessee electronic claims submission at:

<http://www.bcbst.com/providers/ecomm/technical-information.shtml>.

4. Electronic Enrollment Forms

Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums. And original signatures have been eliminated. For questions call (800) 924-7141 and speak "Enrollment".

To enroll in electronic claims filing, to add a provider to an existing electronic practice or make any changes in your electronic filing process you must complete an Electronic Provider Profile Form.

[Access the Electronic Provider Profile Form on Availity](#) for all Providers.

If you would like to make changes to your current electronic mailbox(s), or migrate to the SFG, you must complete the SFG Request for Access form through Availity.

5. Security Information

In order to protect your secure access to our systems, each individual who will be accessing our systems is required to submit the Provider Account Security Form located on our website under Electronic Data Interchange (EDI).

E. Provider Resources

6. BCPTN Provider Website

BCPTN integrates self-service and electronic communication technologies as an efficient, cost-effective means to distribute BCPTN provider information, education, and assistance. We take every opportunity to educate our providers about and encourage the use of our self-service technologies. Our site is located at bluecareplus.bcbst.com.

The Website design offers a user-friendly experience for both members and providers seeking information and assistance regarding the Medicare and Medicaid program. The Website presents appropriate, clear, and accessible information to both members and providers, with effortless access to information while adhering to all 508 accessibility, NCQA, URAC and BCBST standards, policies, and procedures. Our primary goal is to provide healthcare information in an easy-to-use platform with self-service technology and to improve the user experience.

BCPTN Homepage



The following provider resource sections are available on bluecareplus.bcbst.com.

➤ **Provider Administration Manual**

The Provider Administration Manual (PAM) offers information about our programs, and how we work with our members and providers.

➤ **Provider Education and Resources**

The Provider Education and Resources section offers timely and accessible information, including additional education to review at your convenience. We offer a Provider Resource page to assist you with day-to-day operations for providing services to our members.

➤ **Electronic Data Interchange**

Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums.

➤ **Clinical Practice Guidelines**

BCPTN follows the Clinical Practice Guidelines (CPGs) that have been adopted by BlueCross BlueShield of Tennessee. BCPTN may also follow modified Practice Guidelines based on conditions relevant to our member population, TennCare, CMS and/or nationally recognized standards in which there is not a supporting corporate guideline.

Provider Resource Page

Many reference materials are also available online, giving you access to current administrative processes and medical policies. The website contains a “find” feature making it convenient for providers to locate specific information (e.g., billing requirements, UM guidelines, preventive care guidelines, upcoming medical policies and much more).

We invite you to visit the website often. Information, new features and timely information are added regularly.

7. **Availity**

Availity enables you to view the following in real time:

- Up-to-date policy
- Medical and behavioral health claim information
- Eligibility and coverage
- Prior authorizations
- View and/or print your remittance advice

Additional services are available

- PCP Membership Rosters
- Provider Fee Schedules
- Quality Care Rewards (QCR)s

Availity includes e-Health Services® (benefits, claims and authorization information), as well as access to Primary Care Provider member rosters, provider remittance advices and much more. First time users must register to access these online services. Visit [Provider Contact Us | BCBS of Tennessee \(bcbst.com\)](#) to find your contact for Availity technical support.

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v. General Guidelines for Benefits

The scope of the benefits under Medicare Part A and Medicare Part B is defined in the Social Security Act. The scopes of Part A and Part B are discussed in sections 1812 and 1832 of the Act, respectively, while section 1861 of the Act lays out the definition of medical and other health services. Specific health care services must fit into one of these benefit categories or supplemental benefit categories and not be otherwise excluded from coverage under the Medicare program (see §1862 for exclusions).

BCPTN coverage and payment is contingent upon the following:

1. A service must be a covered benefit in a member's Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BCPTN uses the following hierarchy of references to determine coverage:

- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476;
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare's Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare's Internet Only Manuals;
- Local Coverage Determinations (LCDs);
- Coverage guidelines in Interpretive Manuals (Medicare's Internet Only Manuals, sub-manuals)
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
- MCG criteria;
- BlueCross Utilization Guidelines;
- U.S. Food and Drug Administration approved indications for medications;
- Supplemental benefits and limitations as outlined in a member's Evidence of Coverage;
- BCBST Policy; and
- Other major payer policy and peer reviewed literature.

For fully integrated dual eligible (FIDE) members, Medicaid review for items/services not approved under the member's Medicare benefits includes:

- TennCare Rules
- BCBST Medical Policy
- MCG adopted guidelines
- Centers for Medicare & Medicaid Services and Local Coverage Determinations

****Note:** TennCare Exclusion Rule 1200-13-13-.10(1)(n) states "Items or services to the extent that Medicare or a third-party payer is legally responsible to pay or would have been legally responsible to pay except for the enrollee's or the treating provider's failure to comply with the requirements for coverage of such services." Therefore, items denied as not medically necessary under the member's Medicare benefit will not be reviewed for medical necessity under the Medicaid benefit.

BCPTN is a D-SNP HMO for beneficiaries enrolled in Medicare and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the Medicare Saving programs categories that are offered to help members with Medicare pay Medicare cost sharing:

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing like deductibles, coinsurance, and copayments. Some people with QMB are also eligible for full TennCare (Medicaid) benefits (QMB+).

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and are also eligible for full TennCare (Medicaid) benefits.

BCPTN confirms eligibility, including both Medicare eligibility and Medicaid eligibility prior to enrollment.

A BCPTN member's eligibility for enrollment is based on his/her eligibility for Medicaid. Medicaid eligibility is subject to changes due to variation in the enrollee's income from one month to another or to changes in the State's criteria for eligibility. Thus, a dual eligible enrollee of BCPTN may become ineligible for the plan due to the loss of his/her Medicaid eligibility for a period of time that may be one, or many months in duration. When a BCPTN member loses Medicaid eligibility, BCPTN will provide assistance to re-establish a member's Medicaid status.

Please refer to the BlueCare Tennessee Provider Administration Manual for Medicaid benefits for BlueCare Plus Choice members. The manual is located at:

[Manuals, Policies & Guidelines | BCBS of Tennessee](#)

A. Emergent and Urgently Needed Care

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Urgently needed services are covered services that:

- Are not emergency services as defined above, but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when a member is temporarily absent from the BCPTN service area and unable to obtain needed services from a network provider or when a member is in the service area, but the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services from his/her regular network provider after the member returns to the service area or a network provider becomes available.

BCPTN does not require prior approval of emergency or urgently needed covered services.

Stabilization of an Emergency Medical Condition

A physician treating a member is responsible for deciding when the member may be considered stabilized for transfer or discharge.

Post Stabilization Care Services

Post stabilization care services are covered services that are:

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- Related to an emergency medical condition;
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Member Protections Related to Plan-Directed Care

In accordance with Medicare Managed Care Manual Chapter 4, CMS considers a contracted provider an agent of BCPTN. As an agent for us, it is the responsibility of contracted providers to know whether specific items and services are covered in our BCPTN plans. Additionally, contracted providers are expected to coordinate care/services with other contracted providers and ensure the member is receiving medically necessary services. Providers should contact BCPTN UM Department at 1-866-789-6314 or fax clinical information supporting the need for services to be provided by a non-contracted provider to 1-866-325-6698 prior to rendering the service. This does not apply to emergency or urgently needed services as described above.

B. Services, Supplies and Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally, is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be DME. Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member.

Medical supplies of an expendable nature, such as incontinent pads, lamb's wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

For purposes of rental and purchase of DME a member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)). However, an institution may not be considered a member's home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

1. Medical Equipment

Equipment presumptively constituted as medical equipment includes:

- Hospital beds

- Wheelchairs
- Hemodialysis equipment (also covered as a prosthetic device)
- Iron lungs
- Respirators
- Intermittent positive pressure breathing machines
- Medical regulators
- Oxygen tents
- Crutches
- Canes
- Trapeze bars
- Walkers
- Inhalators
- Nebulizers
- Commodes
- Suction machines
- Traction equipment

Special Exception Items

Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

- gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating highly susceptible to ulceration; and
- heat lamps for medical therapy where the need for heat therapy has been established.

Continuous Glucose Monitors Covered Under Part B

Continuous glucose monitors are covered under Part B. Prior authorization is required for non-preferred monitors or out-of-network providers. Continuous glucose monitoring systems supplied only through the pharmacy and not a DME provider include Dexcom. The Eversense implantable monitor and insulin pumps with integrated adjunctive CGMs can also be covered. Supplies limitations per CMS regulations.

Repair, Maintenance, and Replacement of Medically Required DME Repairs

Repairs to equipment a member owns are covered when necessary to make the equipment serviceable after damage or wear. See Non-Covered Benefits section below related to repair, maintenance or replacement of equipment in frequent and substantial servicing or oxygen equipment.

A new physician's order is not needed for repairs.

Maintenance

Extensive maintenance which, based on the manufacturers' recommendations and performed by authorized technicians, is covered as repairs for medically necessary equipment which a member owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

A new physician's order is not needed for covered maintenance.

Replacement

Equipment a member owns or is a capped rental item may be replaced in cases of loss or irreparable damage to a specific accident or a natural disaster such as fire or flood.

A physician's order is needed to reaffirm the medical necessity of the item. Reasonable useful lifetime restrictions apply.

Coverage of Supplies and Accessories

Supplies that are necessary for the effective use of DME are covered. Such supplies include drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.

Preferred diabetic testing supplies covered under Part B include Roche Accu-check products for standard glucometers, and Dexcom for continuous glucose monitors.

2. Prosthetics

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order.

Examples include:

- Artificial limbs
- Parenteral and enteral nutrition and accessories and/or supplies
- Cardiac pacemakers
- Prosthetic lenses
- Breast prostheses including surgical brassiere post mastectomy
- Maxillofacial devices
- Devices replacing all or part of the ear or nose
- Urinary collection and retention system with or without a tube to replace bladder function in case of permanent incontinence
- Foley catheter for permanent urinary incontinence
- Colostomy and other ostomy bags, necessary accessories required for attachment, irrigation/flushing equipment, and other items/supplies directly related to ostomy care, whether the attachment of a bag is required
- Back braces

Prosthetics Replacement

Replacement of a prosthetic device that is an artificial limb, or replacement part of a device is covered if the ordering physician determines that the replacement device or part is necessary because of any of the following:

- a change in the physiological condition of the patient;
- an irreparable change in the condition of the device, or in a part of the device; or
- the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

Prosthetic Supplies, Repairs, Adjustments, and Replacement

Supplies are covered that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition is covered when ordered by a physician. General provisions relating to the repair and replacement of DME as described above for the repair and replacement of prosthetic devices are applicable.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient's condition are covered when ordered by a physician.

C. Chiropractic Services

Manual manipulation and manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine to correct subluxation. In addition, BCPTN covers limited routine visits per year. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

D. Part B Drugs

In order for Part B drugs to be considered for benefits, the service must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury according to National Coverage Determinations and/or Local Coverage Determinations.

Part B drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized

Certain Part B drugs may be subject to Step Therapy requirements for members who are new to start the medication. These drugs are identified with "ST" for Step Therapy. The list of drugs requiring prior authorization and Step Therapy can be found at

<https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf>.

You can also find all Part B Step Therapy requirements at

https://www.bcbst.com/docs/providers/BCBST_Part_B_Step_Therapy_Provider_Reference_Guide.pdf

Certain formulary drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make a determination.

Part B Specialty Pharmacy medication authorizations can be initiated by phone at 1-800-924-7141, or online through Availity, BlueCross' secure portal on its website, www.bcbst.com.

Note: New drugs may be periodically added to the Specialty Pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed on the company website under the News and Updates section at [Provider News and Updates | BCBS of Tennessee \(bcbst.com\)](#).

E. Hospice

Original Medicare, rather than BCPTN, pays for hospice services for a member who has elected hospice. BCPTN will continue to pay for non-hospice and supplemental benefit services.

F. Out of Network Renal Dialysis Services

Prior authorization is required for out of network renal dialysis services.

G. Referral Guidelines

In BCPTN, members will choose or be assigned a Primary Care Physician (PCP) for their health care needs. The PCP is responsible for the coordination of BCPTN members' healthcare and routine health care needs.

BCPTN does not require referrals from a PCP to a contracted specialist. If a member needs to obtain services from a non-contracted provider, a prior authorization is required.

H. Therapy Caps and Exceptions

The statutory Medicare Part B outpatient therapy cap is an annual per beneficiary therapy cap amount determined for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. The annual update is published on The Centers for Medicare and Medicaid, [Therapy Services](#) page. [Prior authorization](#) may be required for therapy services.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists' private practices
- Offices of physicians and certain non-physician practitioners
- Part B skilled nursing facilities
- Home health agencies (Type of Bill (TOB) 34X)
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospital outpatient departments (HOPDs)

I. Behavioral Health Services

BCPTN offers a fully integrated physical and behavioral model designed to serve the needs of its members. Our system of care eliminates the separation of physical and behavioral health and social needs and prevents the fragmentation of services. The cornerstone of this model is the Care Team, which is led by the Primary Care Provider (PCP) and is unique to the member's health care needs. The Care Team is comprised of all individuals responsible for the care of the member, including health care providers, family, state, and community resources, and BCPTN Care Facilitators. The composition of the Care Team may change over time or remain static depending on the needs of the member. Members of the Care Team may be permanent for a member who may have chronic pathology or behavioral health needs. The expectation is that behavioral health providers will be active members of this team ensuring the member's needs are met across time. We believe for managed care to be effective; the delivery of care must occur in an environment where the major participants are working together to achieve the same purpose. An active partnership is essential for significant health improvements to occur in the

BCPTN population. BCPTN strongly believes that members, providers, and our organization are all intertwined by four common interests:

- promoting recovery, resiliency, and wellness
- achieving outcomes
- managing resources
- managing care

Our care management programs are designed to support effective and efficient integration of PCP and behavioral health services through a variety of joint coordination mechanisms within our Utilization Management program and Case Management programs.

1. Care Management

BCPTN Care Management Program helps members stay healthy, address health risks, and manage their chronic conditions, such as schizophrenia, bipolar disorder, and major depressive disorder. BCPTN Care Management services include outreach, health education, care coordination, case management, and more. Services are available to BCPTN members at no extra cost.

BCPTN Care Management evaluates our entire member population for risk factors (not disease categories) to identify members who may benefit from particular Care Management services. We encourage providers to refer members for care management services, as needed. To refer members, please call 1-877-715-9503.

2. Case Management

The BCPTN Case Management program identifies and assesses members who may benefit from community-based services. BCPTN Case Management may contact behavioral health providers to facilitate care coordination for high-risk members.

3. Covered Services

Outpatient/Inpatient Behavioral Health Services

Benefits are available for clinical assessment, diagnosis, and referral, as well as inpatient and outpatient services for treatment of behavioral health disorders (mental health and substance use disorders).

The following grid lists behavioral healthcare Covered Services for BCPTN members:

Service	Benefit Limit/Requirement
Psychiatric inpatient hospital services, including CSU* (including physician services)	As Medically Necessary
Outpatient mental health services (including physician services)	As Medically Necessary
Inpatient, residential & outpatient substance use disorder benefits*	As Medically Necessary
Intensive Outpatient Programs (substance use and psychiatric)***	As Medically Necessary
Partial Hospitalization (substance use and psychiatric)***	As Medically Necessary

Service	Benefit Limit/Requirement
Psychological/Neuropsychological Testing	As Medically Necessary
Electroconvulsive Therapy	As Medically Necessary
Psychiatric Consult on a medical floor	As Medically Necessary
Transcranial Magnetic Stimulation	As Medically Necessary
Medications for Opioid Use Disorder **	As Medically Necessary

*Inpatient, CSU and residential SUD benefits are limited to services located in an Inpatient facility.

Effective 1/1/20 Medications for Opioid Use Disorder include Buprenorphine, Naltrexone and Methadone provided through a network eligible OTP (Opioid Treatment Provider).*Effective 1/1/24 dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who receive Medicaid coverage of services furnished by MFTs or MHCs, or IOP services furnished by hospital outpatient departments, community mental health centers (CMHC), rural health clinics (RHC), federally qualified health centers (FQHC), or opioid treatment programs (OTP), Medicare will become the primary payer for these services provided by Medicare-enrolled practitioners or providers.

4. Prior Authorization

Inpatient and higher levels of care, including Crisis Stabilization Unit, require prior authorization. A prior authorization may be retroactively denied if BCPTN subsequently determines that (1) the healthcare services rendered were not included as Covered Services under the applicable Benefit Plan; (2) such services were not Medically Necessary; (3) the member was ineligible for such services at the time the services were rendered; or (4) the information submitted with the prior authorization request was not accurate or complete.

The following behavioral health levels of care require prior authorization:

- Psychiatric inpatient hospital services
- Inpatient (detox), residential substance use services
- Partial Hospitalization Program (psychiatric only)
- Intensive Outpatient Program
- Transcranial Magnetic Stimulation Therapy

Prior Authorization services for physical and behavioral health services can be arranged by calling the Utilization Management Department Monday through Friday, 8 a.m. to 6 p.m. (ET) at the statewide telephone number listed below:

1-866-789-6314

Requests for urgent services are received and processed telephonically 24 hours a day, 7 days a week. Urgent services are considered:

- Psychiatric inpatient hospital services
- Inpatient substance abuse services (detox)

Providers can submit requests for outpatient services via fax at 1-866-325-6698.

Authorization requests for urgent inpatient behavioral health services need to be submitted within 24 hours of admission or the next business day.

Authorization requests for elective inpatient behavioral health services like residential treatment and any outpatient service requiring prior authorization should be submitted twenty-four (24) hours prior to admission, but no later than one (1) business day after admission.

When a request for an authorization of a procedure, admission/service is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering the care for the day(s) or service(s) that have been denied. BCPTN non-payment is applicable to both the facility and practitioner rendering the care.

5. Medical Necessity Determinations

BCPTN considers the individual needs of each member when making Medical Necessity determinations for Covered Services. We also consider the availability of appropriate service alternatives that exist within the region.

BCPTN determines Medical Necessity on a case-by-case basis using established and approved criteria for behavioral health disorders. Timeframes for determining Medical Necessity are based on National Committee for Quality Assurance (NCQA), and State of Tennessee timeliness standards. Providers who do not submit requested medical information for the purposes of making a Medical Necessity determination for a service shall not be entitled to payment for that service. BlueCare Tennessee can impose financial penalties on a provider who does not comply with an information request for appeals.

Second Opinions

BCPTN provides benefits for a second opinion (in any situation where there is a question concerning diagnosis) when requested by a member, parent, or legally appointed representative.

6. Provider Network Participation

Please be aware that not all disciplines described are eligible for participation in the BCPTN networks. In addition to network participation criteria that applies for all provider networks, providers must also be enrolled in Medicare and Medicaid and complete a Disclosure of Ownership and Control Interest statement in order to receive reimbursement for treating BCPTN members.

If you have questions about network eligibility, please contact your assigned regional BCPTN Provider Network Manager, email ProviderSupport@bcbst.com or call Provider Network Services at 1-800-924-7141 and select either touchtone (Option 1) or voice (say "voice").

7. Treatment Record Requirements

Outpatient Program providers are expected to develop an initial treatment plan within thirty (30) days of the start date of service and update it every six (6) months or more frequently, as clinically appropriate. Evidence of an individualized treatment plan includes, but is not limited to, the following documentation:

- A. A Case Formulation Statement that hypothesizes the member's primary problem(s), states the desired treatment outcomes, describes the therapeutic approach to treatment, and proposes interventions toward desired outcomes;
- B. Identified problems for which the member is seeking treatment;

- C. DSM diagnoses, primary and secondary;
- D. Measurable, attainable, age-appropriate goals and objectives related to the identified problems;
- E. Target dates for completion of goals/objectives;
- F. Information regarding the member's strengths used to develop strengths-based plan;
- G. Services to be used for each goal or objective (e.g., medication management, therapy, community-based treatment services);
- H. Evidence of member's involvement in treatment planning. (*Fulfilling this requirement means that each initial treatment plan and subsequent treatment plan review is signed by a member, family member, or legally appointed representative.*)
- I. Progress notes for each service contact documenting the date and time of service, the type of service provided, a summary of treatment interventions used, the treatment plan goals and objectives addressed in the session, and the name and credentials of service provider.
- J. Documentation of coordination of care efforts and communications with PCPs, other outside providers, agencies, judicial system, member support system, or any other person or entity involved in the member's treatment.
- K. Evidence of discharge planning activities to include discharge plans, dates of follow-up appointments, and referrals to other providers.
- L. A discharge summary completed and documented following discharge from services (see program description for time frame requirements).
- M. For providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate, for each of the different services provided to the member.
- N. Providers should screen for health issues and provide appropriate referrals and coordination of care as needed following this screening. Screening for physical health issues and coordination with primary care physicians should be completed on intake and annually thereafter for each member.

All treatment records must be legible, maintained in a detailed and organized manner, and available at the site where covered services are rendered. Treatment records for ALL LEVELS OF CARE must contain:

Identifying Member Information:

- A. Member name and at least one other piece of identifying information on every page or electronic screen of treatment record. (date of birth, Member ID#, address)
- B. Member contact information including address and phone number
- C. Employment or school information
- D. Marital status
- E. Legal status (including state custody)
- F. Guardianship and/or conservatorship, if applicable

Consent Forms Signed by Member/Parent/Guardian:

- A. Consent for treatment
- B. Informed consent for prescribed medications
- C. Release of information forms, updated annually, for member's PCP, for other behavioral health providers, and for any other providers or agencies relevant to coordination of care
- D. For members with no PCP, documentation must reflect efforts to help a member to obtain a PCP
- E. Release of information form for MCO or payer, communicating to member that provider will share service participation and treatment progress with MCO

F. Acknowledgement of review of patient rights and responsibilities

Likewise, when voluntary inpatient treatment is being considered for adults, BlueCare Tennessee expects providers to inform them or their legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Providers of behavioral health services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of behavioral health services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards. All applicable Tennessee state mandated requirements of the Tenn. Code Ann. § 56-7-2367 (2016) 56-7-2367 for Autism Spectrum Disorders are also followed by BlueCross BlueShield of Tennessee.

Additional resources that provide specific treatment expectations and best practices can be found below:

[MCG Cite Guidelines](#)

[Medicare Coverage Database/Local Coverage Determination](#)

Medication Information Documenting:

- A. All medications prescribed (psychotropic medications as well as medications for other physical health conditions), the dosages of each, and the dates of initial prescription and refills;
- B. If medications are prescribed by an outside provider, the prescriber is identified;
- C. Any medication allergies or adverse reactions are clearly noted; and
- D. For members being considered for psychotropic treatments, documentation must reflect evidence of informing the member and parent or guardian of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

Current Medical Information and Medical History:

- A. A health assessment that includes medical history, screening for current medical problems, currently prescribed medications, and medication history;
- B. Medication allergies, adverse reactions, and relevant medical conditions are clearly documented as present or absent; and

Psychiatric Information and Psychiatric History:

- A. Identification of previous providers and treatment services;
- B. Approximate dates of service for previous providers and treatment services;
- C. Information regarding outcomes of previous treatment services;
- D. A mental status evaluation;
- E. A DSM diagnosis consistent with current symptoms;
- F. Information addressing Member-specific cultural considerations;
- G. Information regarding the Member's list of strengths;
- H. A substance use assessment that screens for frequently used over-the-counter medications, alcohol, tobacco, and other drugs and history of prior alcohol and drug treatment episodes (recommended screening tools are available at <http://bluecare.bcbst.com>);

- I. Current risk assessment (imminent risk of harm, suicidal or homicidal ideation/intent, elopement potential) clearly documented and updated according to written protocols; and
- J. A crisis plan relevant to Member's risk potential that includes individualized steps for prevention or resolution of crisis. This plan should include, but is not limited to:
 - 1. Identifying crisis triggers;
 - 2. Steps to prevent, de-escalate, or defuse crisis situations;
 - 3. Names and phone numbers of contacts who can assist Member in resolving crises; and
 - 4. The Member's preferred treatment options in the event of a crisis.

Additional record requirements apply to SPECIFIC LEVELS OF CARE, as follows:

Outpatient Service Providers:

- A. An intake, initial evaluation, or diagnostic assessment completed within the first thirty (30) calendar days of initiation of services
- B. An initial treatment plan completed within the first thirty (30) calendar days of initiation of services, and an updated treatment plan at least every six (6) months
- C. A progress note completed for each service contact
- D. Documentation of communication with Member's PCP and other behavioral health providers within two (2) weeks of the intake/diagnostic assessment; annual updates to those providers, and notification of discharge from services to those providers; all communication to other providers must include a summary of treatment services, including medications, and any changes to treatment since the previous communication
- E. A discharge/transfer summary that includes Member's condition at the time of discharge/transfer, the reason for discharge/transfer, aftercare recommendations or appointments as applicable, and the signature of person preparing the summary

Substance Use Disorder Services Providers (Inpatient, Residential, & Outpatient):

- A. For detoxification services, documentation of supervision by a Tennessee-licensed Physician with a minimum of daily re-evaluations by a Physician or a registered nurse.

Complaints and Quality of Care Concerns

One method of identifying opportunities for process improvement is to collect and analyze the content of Member complaints and other reported quality of care concerns. These will be reviewed per BlueCross Clinical Risk Management (CRM) Department processes.

Reporting Behavioral Health Adverse Occurrences to BCPTN

Participating providers are required to report all behavioral health adverse occurrences involving members to Behavioral Health Quality Clinical Risk Management within twenty-four (24) business hours. Adverse occurrences are defined as events that represent actual or potential serious harm to the well-being of members or to others by a member who is in behavioral health treatment in Inpatient or Residential levels of care. Report all adverse occurrences to Behavioral Health Clinical Risk Management using the TennCare Adverse Occurrence report form found on the company website at <http://bluecare.bcbst.com/forms/Provider%20Forms/provider-notification-AOR.pdf>.

Examples of reportable adverse occurrences include, but are not limited to the following:

- Suicide death
- Non-suicide death
- Death cause unknown
- Homicide

- Homicide attempt with significant medical intervention*
- Suicide attempt with significant medical intervention*
- Allegation of abuse or neglect including peer-to-peer (physical, sexual, verbal)
- Accidental injury with significant medical intervention*
- Self-injurious behavior with significant medical intervention*
- Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention*
- Treatment complications, including (medication errors and adverse medication reactions requiring significant medical intervention)
- Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting
- Other occurrences representing actual or potential serious harm to a member not listed above

*Significant medical intervention: An event requiring medical intervention that cannot be provided in the behavioral health treatment facility such as an event requiring an ER visit or inpatient hospital stay.

BlueCare Tennessee may undertake an investigation based on the circumstances of each occurrence, or on any identified trend of adverse occurrences. As a result, providers may be asked to furnish records, and/or to engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Providers may also be subject to disciplinary action through BCBST Clinical Risk Management, Provider Participation Status Committee, or the BCBST Credentialing Committee, or all.

8. Contact Us

Providers can locate valuable information, tools and resources on our company websites, bluecareplus.bcbst.com and www.bcbst.com. The websites offer access to comprehensive information and practical recommendations related to addiction and recovery, mental and behavioral health, medications, life events, and daily living skills. Providers having questions or needing to arrange behavioral health/substance abuse services for BCPTN members should either call the Prior Authorization phone line at 1-866-789-6314, Monday through Friday, 8 a.m. to 6 p.m. (ET), or utilize the Prior Authorization fax line 1-866-325-6698.

In the event of a crisis, BCPTN members and providers can call the national crisis hotline for direction to their local crisis team for assistance. For urgent situations, members will be referred to providers in their community that can see them within forty-eight (48) hours.

J. Dental

BCPTN covers Medicare-covered dental services which are limited to surgery of the jaw or related structures that would be provided by a physician. Covered services are limited to:

- Surgery of the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease
- Services that would be covered when provided by a physician

Please note: Effective 1/1/26, members enrolled in BlueCare Plus and BlueCare Plus Select will have supplemental preventive and comprehensive dental coverage with a fixed annual maximum allowance. The provider must submit a claim to Dental Benefit Providers for consideration. Members enrolled in BlueCare Plus Choice will only have dental coverage through the Dental Benefits Manager (DBM) under contract with the Division of TennCare.

Preventive Services

Covered: Routine oral exams up to 2 per year, cleanings up to 2 per year, dental x ray (1 bitewing per 12-month period) (1 panoramic or full mouth x-ray per 36 month period).

Comprehensive Services

Comprehensive dental services will have an annual limit of \$3,000

For Questions related to claims or benefits, contact Dental Benefit Providers at 1-866-238-2630.

K. Therapeutic Shoes for Diabetics

BCPTN provides benefits for the following when the need for therapeutic shoes is certified by a physician:

- One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.

L. Preventive Services

BCPTN covers preventive services including:

- Abdominal aortic aneurysm one-time screening for individuals at risk
 - The plan only covers this screening if they have certain risk factors and if they get a referral for it from their physician, physician assistant, nurse practitioner, or clinical nurse specialist
- Alcohol misuse counseling
- Annual wellness visit
 - If member had Part B for longer than 12 months, they can get an annual wellness visit to develop or update a personalized prevention plan based on their current health and risk factors. This is covered once every 12 months. Note: Their first annual wellness visit can't take place within 12 months of their "Welcome to Medicare" preventive visit. However, they don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after they've had Part B for 12 months
- Bone mass measurement every 24 months for individuals at risk or more frequently if medically necessary
- Breast cancer screening (mammogram)
 - One baseline mammogram between ages 35 and 39
 - One screening mammogram every 12 months for women age 40 and older
 - Clinical breast exam once every 24 months
- Cardiovascular disease screening
 - One visit per year with PCP for risk reduction
 - Blood testing to detect cardiovascular disease once every five years (60 months)
- Cervical and vaginal cancer screening
 - Pap tests and pelvic exams once every 24 months
 - Pap tests every 12 months for any one of these:
 - High risk of cervical or vaginal cancer

- Childbearing age
- Had an abnormal Pap test within the last three years
- Colorectal screening
 - Age 45 or older flexible sigmoidoscopy or barium enema every 48 months
 - Guaiac-based fecal occult blood test or fecal immunochemical test every 12 months
 - DNA based colorectal screening every three years
 - High risk of colon cancer - Screening colonoscopy or barium enema every 24 months
 - Not at high risk of colon cancer – screening colonoscopy every 10 years (120 months) but not within 48 months of screening sigmoidoscopy
- Depression screening one per year in a primary care setting than can provide follow-up treatment and/or referrals
- Diabetes screening including fasting glucose test for any of the following risk factors:
 - Hypertension
 - History of dyslipidemia
 - Obesity
 - History of high blood glucose
 - Based on results of these screenings, member may be eligible for up to two diabetes screenings every 12 months
- Hepatitis C screening
 - We cover a one-time Hepatitis C screening test. We also cover repeat screening annually for certain people at high risk.
- HIV screening
 - Individuals who ask for screening test or at high risk for HIV infection one screening exam every 12 months
 - Women who are pregnant up to three screening exams during pregnancy
- Immunizations, including influenza, hepatitis B and pneumococcal
 - Covered Medicare Part B services include:
 - Pneumonia vaccine
 - Flu shots, once each flu season in the fall and winter with additional flu shots if medically necessary
 - Hepatitis B vaccine if they are at high or intermediate risk of getting Hepatitis B •
 - COVID-19 vaccine
 - Other vaccines if they are at risk and they meet Medicare Part B coverage rules
 - We also cover some vaccines under our Part D prescription drug benefit.
 - Tdap (Tetanus, Diphtheria and Pertussis (Whooping Cough))
 - Shingles
- Medical nutrition therapy services for individuals with any of the following:
 - Diabetes
 - Renal disease not on dialysis
 - Post kidney transplant
- Medicare Diabetes Prevention Program
 - MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change

intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle

- Obesity screening and counseling
- Prostate cancer screenings (PSA)
 - For men age 50 and older, covered services include the following:
 - Once every 12 months:
 - Digital rectal exam
 - Prostate Specific Antigen (PSA) test
- Screening and counseling to reduce alcohol misuse
 - We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If the members screen positive for alcohol misuse, they can get up to 4 brief face-to-face counseling sessions per year (if they're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.
- Screening for lung cancer with low dose computed tomography (LDCT)
 - Eligible members ages 50-77 who have no sign of lung cancer but history of smoking at least 30 packs per year and currently smoke or have quit in the past 15 years
 - Once every 12 months
- Sexually transmitted infections (STI's) and counseling to prevent STI's
 - We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit (one-time)

Additional requirements may be required for some screenings. Refer to the Evidence of Coverage located at bluecareplus.bcbst.com for additional information.

M. Hearing Services

BCPTN combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as routine hearing exams, hearing aid fittings and evaluations, hearing aids and batteries, and hearing aid repairs and adjustments provided through TruHearing. Contact TruHearing at 1-833-414-8998.

N. Over the Counter (OTC)

There is no coinsurance, copayment, or deductible for covered OTC items. The maximum combined coverage amount for covered OTC/Healthy Food/ items is depending on the member's benefit package. Any unused amount will expire at the end of each month.

Over the counter (OTC) Items/Healthy Food

We provide a debit card (Flex Card) that gives members a fixed dollar amount each month to buy certain OTC products and healthy food at participating retail locations. Members can also place an order for OTC products online, over the phone, or by mail through the OTC catalog that will be sent to them. Their items will ship directly to them. This card is used for both benefits and provides a combined monthly allowance. The healthy food benefit listed is a special supplemental benefit for members with certain chronic conditions. Qualifying chronic conditions include, but are not limited to, cardiovascular disorders, diabetes mellitus, obesity, chronic lung disorders and chronic gastrointestinal disorders. Additional qualifying conditions exist. See plan materials for complete list. Not all members (even those with a qualifying condition) qualify. Eligibility is based on meeting the CMS definition of “chronically ill enrollee” and all applicable plan coverage criteria.

Over the counter (OTC) items (Supplemental)

Coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages. Members can order: Online – visit BlueCarePlusOTC.com By Phone – call an OTC Advocate toll-free at (855) 243- 1186 (TTY/TDD: 711), Monday to Friday, 8 a.m. to 11 p.m. (Eastern Standard Time), excluding holidays By Mail – fill out and return the OTC Order Form in the OTC Product Catalog by Mobile Application (Mobile App) – download our OTC-Anywhere mobile app and access the app from their smartphone or tablet to place their order. There is no charge to download or use the app. This app works on mobile devices using Apple or Android operating systems. Retail Payment Card - members will receive a retail payment card to purchase OTC allowed items at participating retail locations. The card will be mailed with instructions for use. Their OTC order will be shipped to the address given when ordering. Shipping will not cost anything. Refer to the 2026 OTC Product Catalog for a complete list of plan-approved OTC items or call an OTC Advocate for more information. Members will find important information (order guidelines) in the 2026 OTC Product Catalog. Healthy Food: Their coverage may include healthy food like fruits, vegetables, and select canned goods. They will qualify for the healthy food benefit if they have certain qualifying conditions. Members will be notified if they are eligible. They will receive a debit card to purchase approved healthy food items at participating retail locations. Healthy Food retail purchase information will be mailed with their debit card. The monthly allowance cannot be used to purchase firearms, ammunition, weaponry, tobacco or alcohol.

O. Podiatry Services

Covered services include:

- Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)
- Routine foot care for members with certain medical conditions affecting the lower limbs
- In addition, BCPTN covers limited routine foot care that is considered preventative such as cutting or removal of corns, warts, calluses, or nails (up to 6 visits).

P. Cardiac Rehabilitation Services

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.

The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous

or more intense than cardiac rehabilitation programs. Two one-hour sessions per day for up to 36 sessions per service per year are covered.

Q. Pulmonary Rehabilitation Services

Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a doctor's order from the treating physician. BCPTN covers two one-hour sessions per day for up to 36 sessions with an additional 36 sessions if medically necessary.

R. Transportation

Our plan provides transportation for plan-approved medical, vision, hearing appointments, pharmacy and fitness center visits and non-emergency ambulance rides that are not covered by the member's Medicaid plan using a shared monthly allowance loaded onto the members FlexCard

Travel is limited to 50 miles from pick-up location.

There is no coinsurance, copayment, or deductible for plan-approved transportation.

S. Vision Services

Through a partnership with EyeMed, BCPTN combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as routine vision exams, frames, lenses and contact lenses. Members have a \$400 annual coverage limit for frames/lens or contact lenses. There is a limit of one routine eye exam and one pair of frames/lenses or contact lenses. In addition to the annual coverage limit, BCPTN members have coverage for:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.
- For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older
- For people with diabetes, screening for diabetic retinopathy is covered once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If they have two separate cataract operations, they cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant are also covered.

Vision Frequently Asked Questions

Why was EyeMed Vision Care chosen to administer the BlueCare Plus Tennessee Vision product?

By choosing EyeMed, we're able to allow members a variety of private practitioners, as well as retail outlets.

Will I submit Vision claims to BlueCross or EyeMed?

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Routine Vision claims should be submitted to EyeMed. If a claim is sent to BlueCare Tennessee in error, it'll be returned to the provider with instructions to resubmit to EyeMed.

How can I contact EyeMed directly?

EyeMed has dedicated a customer service line for our members and providers. The number to call is 1-888-581-3648.

Who do I contact to verify eligibility and check claim status for members that have routine benefits provided through EyeMed?

You'll need to contact EyeMed Customer Service at 1-888-581-3648.

If the services rendered are medical and not considered routine, where should I submit the claim?

Claims of medical services should be filed directly to BlueCare Plus Tennessee.

I'm interested in becoming a provider with EyeMed. Who should I contact?

You'll need to contact EyeMed directly by calling 1-877-342-0737.

T. Health and Wellness

Our health and wellness programs are available to all members at no additional cost. They are designed to assist members with improving healthy behaviors.

➤ **Health Education:**

Wellness Services: Interactive wellness services include general preventive education and reminders for certain preventive screening tests appropriate for age, sex, and claims history. This is through web-based coaching and telephonic based coaching provided by population health staff.

➤ **Fitness Membership:**

The Silver&Fit® Healthy Aging and Exercise Program: As a member, they have the following choices available at no cost to them: • Fitness center membership: They can go to a Silver&Fit participating fitness center near them. • A customized program for their exercise of choice, including instructions on how to get started and suggested online workout videos. • On-demand videos through the website digital library. • Online Health Aging classes

➤ **Enhanced Disease Management:**

If they have CHF, COPD, diabetes, hypertension, hypercholesterolemia, or Stage 4 or 5 chronic kidney disease, they may have access to enhanced disease management. In this program, members are assessed and coached by certified case management nurses in compliance with their doctor's plan of care and educated in ways to control and manage their chronic diseases. Members are monitored relative to prescription medication compliance, ER and inpatient utilization and PCP/Specialist visits. This information is shared with the treating provider as it is necessary to help coordinate services.

➤ **Remote Access Technology:**

- Nurse Hotline: They have access to a 24-hour telephonic nurse hotline, where an R.N. level nurse can assist with general health information, referral guidance to a local clinician or triage some conditions for immediate evaluation versus next day follow-up with your PCP or specialist.

- Tele-Monitoring: Home-based monitoring when medically necessary for members with chronic conditions who are participating in condition management programs and are at increased risk for medical interventions or hospitalization. Frequency of monitoring is based on condition severity. Abnormal results are appropriately shared with the treating physician, while normal results are shared monthly. This monitoring does not include blood glucose monitoring devices covered by Original Medicare.

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VI. Non-Covered Benefits

A. General Exclusions

General exclusions from coverage for certain items or services for which BCPTN cannot pay claims under the Medicare benefit include:

- Not reasonable and necessary
- No legal obligation to pay for or provide (will be paid by other entity)
 - Automobile insurance;
 - No-fault insurance;
 - Liability insurance; or
 - Workers' Compensation (WC) law or plan of the U.S. or a State.
- Paid for by governmental entity
- Not provided within United States
- Resulting from war
- Personal comfort
 - Items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member
 - Examples: Items such as radio, television, telephone, air conditioner, and beauty and barber services
- Routine services and appliances unless covered as a supplemental benefit and described above in the coverage section
- Custodial care*
 - Personal care that does not require continued attention of trained medical or paramedical personnel
 - Assistance in walking, getting in and out of bed, bathing, dressing, feeding, using toilet, preparation of special diets, and supervision of medications that usually can be self-administered
- Cosmetic surgery and expenses incurred in connection with cosmetic surgery
- Charges by immediate relatives or members of household*
- Paid or expected to be paid under worker's compensation
- Non-physician services related to and required as a result of services which are not covered under Original Medicare
- Excluded foot services and supportive devices for feet
 - Treatment of flat foot
 - Orthopedic shoes unless for a member with diabetes or if an integral part of a leg brace
- Excluded investigational devices
- Self-administered drugs - BCPTN adheres to the Cahaba Government Benefit Administrators, LLC Self-Administered Drug (SAD) Exclusion List.

The non-covered benefits listing contained in this section is not an all-inclusive list. It is intended to be a general summary and does not take place of regulations and plan requirements. Refer to IOM Medicare Benefit Policy Manual Publication 100-02 Chapter 16.

Exclusions for coverage under the Medicaid benefit as described in TennCare rule 1200-13-13-.10

B. Services and Supplies Denied as Bundled or Included in the Basic Allowance of another Service

Services and supplies that are bundled or included in the basic allowance of another service will not be paid.

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (e.g., telephone calls to and from the beneficiary); and
- Supplies included in the basic allowance of a procedure.

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VII. Pharmacy

In addition to the drugs covered by Medicare, some prescription drugs are covered for BCPTN members under Medicaid benefits. The member may contact Medicaid for more information about drugs covered under their Medicaid coverage.

BCPTN will generally cover drugs under these basic rules:

- The member must have a network provider write the prescription
- The member must use a network pharmacy to fill prescriptions
- The drug must be on the plan's *List of Covered Drugs (Formulary)*
- The drug must be used for a medically accepted indication.
 - Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
 - or*
 - Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

BCPTN offers a "List of Covered Drugs (Formulary)" available on the BCPTN Website at

https://bluecareplus.bcbst.com/docs/2026_bluecare_plus_formulary.pdf

The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The meets requirements set by Medicare. Medicare has approved the plan's Drug List.

A. Prior Authorization

Certain drugs with special indications require authorization. These drugs are noted on the formulary. For BCPTN the prescribing practitioner, enrollee, or enrollee representative is responsible for obtaining the necessary authorization. Prior authorization must be obtained before the drug is dispensed. You may request prior authorization by contacting the following:

Member Services Line: 1-800-332-5762 (TTY Users Call: 711)

Provider Services Line: 1-800-299-1407

Provider Services Fax: 423-591-9514

Website: <http://bluecareplus.bcbst.com>

Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. Greater quantities require practitioner request for Medical Necessity.

Member Services Line: 1-800-332-5762 (TTY Users Call: 711)

Provider Services Line: 1-800-299-1407

Provider Services Fax: 423-591-9514

Website: <http://bluecareplus.bcbst.com>

Redetermination

If BCPTN has made an adverse determination and denied a member's request for coverage of (or payment for) a prescription drug, a member or the member's physician has the right to ask for a redetermination (appeal) of our decision. A member or the member's physician has 65

days from the date of the Notice of Denial of Medicare Prescription Drug Coverage to ask for a redetermination. Redetermination requests must be in writing or by fax. Urgent requests for redetermination may be requested by phone.

Member Services Line: 1-800-332-5762 (TTY Users Call: 711)

Provider Services Line: 1-800-299-1407

Provider Services Fax: 423-591-9514

Website: [Request for Redetermination of Prescription Drug Denial](#)

Mailing Address:

BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Who May Make a Request: The member or any prescriber may ask for an appeal on the member's behalf. If a member wants another individual (such as a family member or friend) to request an appeal for the member, that individual must be the member's representative. Contact us to learn how to name a representative.

Peer to Peer

At any time, prescribers may request a peer to peer review for Medicare pharmacy reviews. To initiate a peer to peer review, please contact provider services at 1-800-299-1407.

Pharmacy Directory

The BCPTN Pharmacy Directory is available on the BCPTN Website. Please log in to BlueAccess, hover your mouse over the "Find Care" tab, and click "Find a Doctor." Then, select "Pharmacy" in the drop down menu, and click the magnifying glass to find in-network pharmacies close to you.

Formulary Exceptions

An exception is a type of coverage determination that is unique to the Part D benefit. A member, member's authorized representative or member's prescribing physician may request a Formulary Exception.

Formulary Exception ensures that members have access to medically necessary Part D drugs that are not included on the BCPTN formulary. This request also permits members to request an exception to a quantity or dose limitation or a requirement that the member try another drug before BCPTN will pay for the requested drug.

The Physician's supporting statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be as effective because:

- All covered Part D drugs of the BCPTN formulary would not be as effective for the member as the non-formulary drug, and/or would have adverse effects;
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the member's disease or medical condition or,
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, the amount of the drug is likely to be ineffective or adversely affect the patient or patient's compliance; or

- The prescription drug alternative(s) listed on BCPTN is required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the member's disease or medical condition or, based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
 - Has caused or - based on sound clinical evidence and medical and scientific evidence - is likely to cause and adverse reaction or other harm to the member.

B. Identification Card (ID)

Every BCPTN member receives an ID card reflecting the benefit plan and product for the member enrolled. The member ID includes all information necessary for all benefits, including pharmacy. Please refer to Chapter III, Section B for more information regarding member ID cards.

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VIII. Model of Care (MOC) D-SNP

BCPTN offers a Special Needs Plan (SNP) for our dually eligible members that have Medicare Part A and Part B and are Medicaid qualified.

A. SNP Target Population

The BCPTN Tennessee Model of Care (MOC) is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs. Coverage under BCPTN Tennessee three plan options: BlueCare Plus (HMO D-SNP), BlueCare Plus Choice (HMO D-SNP), and BlueCare Plus Select (HMO D-SNP).

The Dual eligible membership includes those individuals with diverse needs, and requires a blend of medical, long-term care, behavioral health, and social services. Enrollees will receive fully integrated physical and behavioral health services designed to serve their individual needs. Medicare and Medicaid eligible members will receive a seamless continuum of care through BCPTN's Care Coordination process.

B. Model of Care Overview

Our Model of Care is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic, or catastrophic health care needs.

Our Model of Care focuses on:

- Case Management across settings and providers and seamless transitions of care and coordination with Medicaid MCOs for Medicaid services
- Inpatient care coordination with an emphasis on effective discharge planning and post-discharge follow-up to reduce the likelihood of readmissions
- Behavioral health and health related social supports care coordination
- Nursing facility care coordination including services for members receiving inpatient hospice and in long-term care facilities
- Home and Community-Based Services care coordination including long-term home health and private duty nursing (Medicaid Benefit) services
- Services for members with complex chronic conditions with a concentration on evidence-based care, medication management and monitoring access to care
- Preventive and health promotion services
- Health outcomes
- Social Determinants

Our model of care includes:

- A member centric Interdisciplinary Care Team (ICT) consisting of health plan medical and behavioral health clinical professionals, members and their caregivers, Primary Care Physicians (PCP), specialty physicians, and other providers caring for frail and chronically ill members. The ICT will be the primary facilitator of care management to ensure efficiency and continuity of services. The comprehensive team of health care professionals will develop and implement an individualized care plan to address a member's medical, behavioral health, psychosocial and long-term care needs.

- A Care Coordination Team to improve care coordination and care transitions and are responsible for engaging members to participate in his or her ICT and develop an individualized plan of care.
- Clinical programs built on evidence-based medicine that have effective outcomes are reported for continuous quality improvement.
- A structured Model of Care training program for network providers to ensure application of integrated care management strategies.

In addition, the Special Needs Population may receive the following interventions as indicated by their Individualized Care Plan (ICP):

- Initial assessment and other assessments done annually
- Coordination of multiple services, such as home health, PT, OT, wound care, DME and specialty services.
- Referral for health coaching or disease management.
- Surveillance for potential status changes such as ER visits, hospitalizations and medical, behavioral health, and pharmaceutical claims data.
- Care Coordination Team contacts the member at a minimum of annually and more frequently as indicated by member needs and/or care plan goals
- Case management/ICT follow-up and care plan update with member/natural supports caregiver as needed when there are any status changes.

C. Staff Structure and Care Management Roles

Staffing for BCPTN includes BlueCare Tennessee staff dedicated to the BCPTN program, BlueCare staff that support both the BCPTN program and administer our Medicaid product, as well as BCBST corporate staff to support central functions such as Enterprise Information Technology, credentialing, provider network contracting and provider relations. BCBST Medicare Advantage enrollment staff support BCPTN Tennessee enrollment processes. Staff structure and roles are organized to perform administrative, clinical, and combined administrative/clinical oversight functions to support our dual eligible population.

BCPTN has a multi-disciplinary Care Coordination Team who administers case management activities. The non-clinical staff coordinates benefits, plan information, conducts member outreach, and obtains data from members and network providers. Registered nurses and licensed behavioral health staff perform clinical functions; maintaining a coordinated care management process, education and clinical care. Both non-clinical and clinical staff monitor the Model of Care compliance, ensuring statutory and regulatory compliance and monitoring care management effectiveness to provide a coordinated plan of care for each member.

In addition to the Care Coordination Team, BCPTN has a Member Education and Outreach department that conducts health education and direct outreach aimed to enhance the member's health and well-being. All new members receive a welcome call from this team, and outreach is conducted to members throughout the year to complete the health assessment and help members address gaps in care. Additionally, this team conducts provider outreach to assist in gap closure, medication adherence, and obtain necessary medical records.

D. Specialized Provider Network

Coordinating the MOC and case management requires a specialized provider network. BCPTN ensures providers are actively licensed and competent. As well as informed of statutory and regulatory compliance and participating in the Interdisciplinary Care Team (ICT) for the BCPTN members to deliver specialized services in a timely and quality manner, providers are expected

to use evidence-based clinical practice guidelines and nationally recognized protocols. For additional information on participating in BCPTN visit our website, bluecareplus.bcbst.com.

The specialized provider network expertise may include, but is not limited to, primary care, internal medicine, endocrinologists, cardiologists, oncologists, facilities, ancillaries, and mental health specialists. We monitor the provider network to identify if other specialists are needed to address and manage the needs of the SNP's target population. BCPTN maintains a comprehensive network of primary care providers, facilities, specialists, and ancillary services to meet the needs of SNP members with chronic disease, such as diabetes, cardiac, respiratory, musculoskeletal and neurological disease and behavioral health disorders. A full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, and outpatient pharmacies allow SNP members to obtain the services they need at a convenient location. The BCPTN website also has a user-friendly search function for members to locate providers and specialists in their area.

Credentialing occurs initially during the application process for any provider applying to participate in the BCPTN Network. Once a provider is approved to participate in the network, they must be re-credentialed based on the service types each provider offers. The credentialing process assures that licensed physicians, organizations, and other health care practitioners within the provider network are qualified to provide health care services to BCPTN members.

Network providers are educated on the coordination of Medicare and Medicaid benefits for which members are eligible. BCPTN offers a self-study and attestation through the BCPTN Website. The attestation can be submitted for verification of the annual MOC training and is found on our website at [BCPTN Model of Care Attestation \(bcbst.com\)](http://BCPTN Model of Care Attestation (bcbst.com)). Annual MOC training will be in print form and available through Provider Resources section of the BCPTN Website. If additional training is requested, the Corporate Provider Relations Network Managers and/or BCPTN's Provider Representative will conduct the training through telephonic outreach or face-to-face provider visits.

BCPTN will not interfere with health professional advice to members regarding member's care and treatment options, as documented and communicated to providers in the BCPTN Provider Administration Manual.

BCPTN encourages open patient communication regarding appropriate treatment alternatives. Providers are not penalized for discussing medically necessary or medically appropriate care with patients.

E. New Provider Orientation and Training

New provider orientation and training will be provided after the completion of contracting and credentialing. The provider will be sent a welcome letter with the effective date and the network manager assigned. The welcome letter includes online resources and a link to this Provider Administration Manual. This manual serves as a source of information for BCPTN.

Network physicians are required to complete Model of Care (MOC) training. In addition, BCPTN offers the training to out of network providers. The MOC training is updated annually and offered via provider self-study and attestation on the BCPTN provider website. Providers are encouraged to take the training at initial contracting and annually thereafter at the beginning of

each calendar year. To be compliant, providers must complete the MOC training on or before 12/31 of each year.

BCPTN offers training that is tailored to the needs of those providers and billing staff that provide services to dual eligible members. The training offers fundamental Medicare policies, programs, and procedures and with a concentration on and information on billing BCPTN.

F. Provider Education and Ongoing Training

BCPTN offers a provider service program to assist providers in understanding and complying with the operational processes, policies and billing procedures for the dually eligible population. The outreach program serves to strengthen and enhance ongoing efforts to continuously improve provider satisfaction through timely delivery of accurate and consistent information. The provider outreach will enable providers to understand, manage and bill BCPTN correctly thus reducing the paid claims error rate and improper payments.

The provider outreach area utilizes a variety of strategies and methods to offer providers a broad range of information regarding the BCPTN program. Methods include print, the provider resources section of the website at bluecareplus.bcbst.com, face-to-face instruction, web-based training and presentations.

Additional training is provided in partnership with BCBST for the All Blue Workshops, Tennessee Medical Association (TMA) and other associations throughout the state of Tennessee. The venues include program overview and feature resource centers with one-on-one consultations with staff members from providers' offices.

BCPTN D-SNPSM updates and/or changes are communicated through the [BlueAlert](#) Newsletter published monthly and/or the quarterly Provider Administration Manual (PAM releases).

G. Health Needs Assessment

At enrollment, BCPTN identifies a member's health status through an initial health needs assessment (HNA) completed for each member within 90 days of enrollment, at least annually thereafter, and potentially with any change in the member's health status. Using a person-centered approach, the assessment identifies the medical, psychosocial, functional, behavioral, and cognitive needs of the member. BCPTN Care Coordination Teams use this information to analyze and stratify a member's risk level and then develop an individualized care plan (ICP). For members receiving LTSS, the HRA and ICP will incorporate information from the Comprehensive Needs Assessment (CNA) and Person-Centered Support Plan (PCSP) using a person-centered approach.

Portions of the HNA information along with the ICP are shared with the member's individual Interdisciplinary Care Team (ICT) for review and collaboration. The ICT should include the Primary Care Provider (PCP) and other treating providers as indicated by the member to facilitate collaboration with all providers who are treating that member. See section J for additional ICT information.

H. Individualized Care Plan (ICP)

The ICP includes prioritized goals (short and long-term) that consider self-management goals, healthcare preferences, and level of involvement in the case management plan.

Each BCPTN member has an individualized care plan. A written plan of care is sent to a member's PCP for input and revision to the member's ICP. Any revisions to the ICP should be returned to BCPTN via telephone, writing or fax. The written ICP prepared by BCPTN and submitted to a PCP is intended to assist the PCP in obtaining necessary information and helping to coordinate and manage his or her member.

The member and/or caregiver will receive a copy of the care plan as well; our hope is that this single document reflects the entire continuum of the member's health care needs and services. Additionally, as applicable, other treating providers will be issued a copy of the written ICP.

For members enrolled in BlueCare Plus Choice, all individualized care plans are developed through home visits as feasible and documented in the Person-Centered Support Plan (PCSP) and the member's Individualized Care Plan, as required in the State Medicaid Agency Contracts (SMAC).

For members who declined to participate in care management or failed to return a written assessment with their specific needs and preferences, claims and pharmacy data are used to develop their ICP.

I. Interdisciplinary Care Team (ICT)

Each member will have his or her own personal Interdisciplinary Care Team (ICT). A member's PCP is a crucial component of the member's ICT. At the center of the ICT are the member and/or caregiver(s), the PCP, the BCPTN Care Coordination team, and based on the members' expressed needs, preferences, clinical condition, and/or living situation, the ICT expands to include appropriate specialists, professionals and community supports.

PCP/providers and other ICT participants, if applicable, may participate through the methods listed below:

- Return of the Patient Assessment and Care Planning Form (PACF)
- Medical records submitted in response to the PACF
- Medical records obtained during care management activities
- Receipt of the member's individualized ICP
- Returned response to mailed ICP
- Face to face with a member during a physician office visit
- Information obtained by the Care Coordination Team during a conversation with a provider's office or a facility discharge coordinator, including case rounds
- Medication reconciliation post-discharge documentation

The purpose of the ICT is to ensure appropriate communication related to a member's health and health care needs that results in:

- Better coordination of services for the member
- Enhanced member understanding
- Informed decision-making
- Safer medication practice
- Better adherence to prescribed medication
- Better self-management of chronic disease
- Reduced hospitalizations or readmissions

BCPTN will reimburse the PCPs \$54 for each ICT they participate in via one of the methods described above. PCPs may use the following codes for claims submission for ICT participation.

99366 - Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional

99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

99368 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

If the PCP participates and the patient is in the office, the PCP should also bill the appropriate office visit evaluation and management code (e.g., 99211 through 99215).

The BCPTN Medical Director and Care Coordination Team conducts case rounds at least monthly to evaluate the health status of members who need immediate attention or have complex health issues and to discuss health care options. PCPs and other treating providers may be contacted to participate in case rounds if necessary, and that participation also counts as an ICT.

J. Performance and Health Outcome Measurement

The overall quality performance improvement plan evaluates to ensure appropriate services are being delivered to the special needs of the BCPTN members by analyzing a comprehensive set of utilization, access, satisfaction, and clinical measures to evaluate improvement and effectiveness of the Model of Care in order to identify areas for improvement. The Quality Improvement (QI) Program operates in a systematic, coordinated, and continuous manner to improve the health of the dual eligible member. The evaluation processes include assessing trends and establishing actions to improve the outcome of identified problems. The Model of Care has structures and processes to continuously improve the quality of care, safety, and appropriateness of services provided to the BCPTN members. The MOC is continually reviewed for performance improvement opportunities and utilizes evidence based best practices.

BCPTN collects, evaluates, analyzes, and reports performance and outcome measurements for the D-SNP program. Internal quality specialists continually review the outcomes to enhance and improve the MOC. Communication of these improvements and updates are published through the BlueAlert, BCPTN Website, Provider Quality newsletters and announcements. BCPTN utilizes an electronic messaging system and the Provider website to keep providers up to date with changes and enhancements. Additionally, BCPTN will include the Medicare Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Healthcare Effectiveness Data and Information Set (HEDIS) and The Center for Medicare & Medicaid STARS programs to measure in evaluating, analyzing and improving the BCPTN program.

Established quantitative measures evaluate performance for issues identified in the HNA, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT) and the MOC. Each measure is objective, quantifiable based on current scientific knowledge and has an established goal and/or benchmark. These measures may include Health Effectiveness Data and Information Set (HEDIS) Effectiveness of Care measures; Use of Services measures; measurement of outcomes related to approved plan clinical practice guidelines or chronic condition management systems, or other issues that are relevant to the population. This provides BCPTN an objective means to help identify special populations, geographical needs, identify

trends and help prioritize opportunities. BCPTN will continue to review performance and outcomes to enhance the Health Needs Assessment and Model of Care to improve and strengthen the program. For additional information and updates visit <http://bluecareplus.bcbst.com/provider-resources>.

K. Integrated Communication Network

BCPTN coordinates the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and members. Our communication structure includes web-based network, audio conferencing and face-to-face meetings. Included in the provider resources is a request form for additional training. Training is provided as feasible through different methods; web conferencing, telephone conferencing and on site as permitted. The website will be the preferred method of communication for updates and changes for both the member and provider.

L. Measurable Goals

Measurable goals are identified and reviewed for optimum care for BCPTN members. BCPTN has outlined the goals below in accordance with The Centers for Medicare & Medicaid (CMS) guidelines for program management:

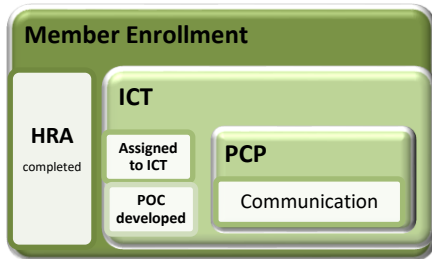
- Improving access to essential services such as medical, mental health, and social services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across healthcare settings, providers, and health services
- Improving access to preventive health services
- Ensuring appropriate utilization of services
- Improving beneficiary health outcomes

BCPTN uses evidence-based guidelines to structure and achieve care management goals and the structure of the Care Management program was designed based on the SNP structure and process measures developed by the National Committee for Quality Assurance (NCQA) and CMS' Special Needs Plans model and requirements.

BCPTN periodically monitors, analyzes, and/or evaluates the rate of progression toward goals by identifying and addressing any barriers impeding goal achievement and identifying opportunities for improvement. The program was designed to ensure members have access to essential, affordable and cost-effective care based on continual assessment and measurable outcomes.

The key indicators are evaluated and reported annually in the Model of Care evaluation to determine whether further actions are required to meet the needs of the BCPTN's dual membership.

M. Model of Care Process Summary



In summary, the BCPTN Tennessee Model of Care (MOC) is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs. Coverage under BCPTN Tennessee includes three plan options: BlueCare Plus, BlueCare Plus Choice and BlueCare Plus Select.

Following enrollment of the member with a BCPTN plan, a health needs assessment will be conducted, and the information will be used to design coordinated care for special needs members through an interdisciplinary care team (ICT) and an individualized plan of care.

The purpose of the ICT is to consistently collaborate to solve a member's health care problems that may be complex to provide for efficient health care. As a health care provider for a BCPTN member, you are encouraged to participate in an individual member's ICT on an annual basis. The ICT is responsible for analyzing the results of the initial and annual health needs assessments and incorporating those findings into an individualized plan of care, collaborating to develop and, at least annually, update the member's plan of care, and manage physical and behavioral health, functional and social support needs of the member. BCPTN will make every effort to have the member participate in his or her ICT, if feasible.

To contact BCPTN for additional information call the numbers below:

Provider Contact 1-800 299-1407
Members Contact 1-800 332-5762

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IX. Care Management

The BCPTN Care Management Program promotes member empowerment regarding health care decisions, education on health conditions and options, as well as the tools and resources necessary to assist the member/family when making health care decisions. The BCPTN Care Management Program also offer quality and cost-effective coordination of care for members with complicated care needs, chronic illnesses and/or catastrophic illnesses or injuries.

The Care Management Program provides the following services for all BCPTN programs:

- Discharge/transition management
- Care Coordination: services including Medicare, Medicaid and Long-Term Support Services
- Telemonitoring for members with congestive heart failure or chronic obstruction pulmonary disease and on oxygen
- Complex Case Management
- Transplant Case Management
- Catastrophic Care Management

Catastrophic Care Management focuses on the most vulnerable members who:

- Are frail with functional limitations
- Have mental, cognitive or physical disabilities
- Have end-stage renal disease
- Are near end of life
- Have multiple and chronic medical conditions complicated by mental health issues (such as depression, bipolar disorder, schizophrenia or dementia) or social disparities (such as homelessness or lack of adequate supports).

A. Referrals and Triage

Members, family and/or caregivers, practitioners and providers are encouraged to initiate referrals for any of the above listed programs and services. A Care Coordination team member will contact the designated person upon receipt of the referral.

B. Discharge Planning/Transition of Care

Transition of Care (TOC) is a member-centric program collaborating with facilities and providers to assure safe transition of members to appropriate levels of care for better health and optimal outcomes. Members have the option to choose a telephonic or digital participation method of communication. Dedicated staff will assist facility discharge planners, physicians and members with understanding requirements, benefits and options for discharge.

The role of the Care Coordination Team is to assist the PCP or other treating providers to manage transitions by coordinating follow-up care and services. The team assures timeliness of services throughout the transition process by conducting medication reconciliation, ensuring a member has a post-admission follow-up physician visit, educating the member on self-management activities and providing tips to avoid re-hospitalization, and setting up meals post discharge as needed.

Routine rounds are held with the Medical Directors to discuss complex medical care needs and concerns. The Care Coordination Team will perform post-discharge calls to the members that include review of discharge instruction, medication reconciliation, confirmation of, or assistance with Physician appointment scheduling, collaboration with community services and review of

home safety to maximize opportunities for positive health outcomes and help decrease readmissions.

CMS requires BCPTN to assist with discharge planning and transition of care for all members transitioning to a different setting. BCPTN prioritizes its focus on assisting with transitions for inpatient services including:

- Medical and Behavioral Health inpatient admissions
- Long-term Acute Care admissions
- SNF admissions
- Inpatient Rehabilitation admissions

The Division of TennCare also requires BCPTN to perform specific transition activities for CHOICES members in an acute inpatient facility.

It is extremely important for BCPTN to be notified of discharge plans and the discharge date for all BCPTN members for timely intervention by the BCPTN Care Coordination team upon discharge.

If during a transition of care, a member needs Medicaid services, the BCPTN Care Coordination team will coordinate with the Medicaid MCO Care Coordinator to arrange for those services. BCPTN also sends electronic notification to each Medicaid MCO regarding BCPTN acute inpatient admissions.

As required by CMS, as a result of a transition, a member's ICP may be updated related to the condition for which he or she was in the hospital and a copy will be mailed to the member or caregiver, PCP, and other treating providers as necessary.

C. Case Management

Care management services involve the full spectrum of care coordination. Case management is intended to stabilize members' health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management. Providers are encouraged to make referrals to the program.

Case management assists with the determination for admission and need for concurrent review (as explained under the Concurrent Review section of this Program Description) for any Skilled Nursing Facility (SNF), as needed. As with the Utilization Management Program, this Health Management program adheres to CMS Medicare Advantage rules and regulations promulgated in 42 CFR-422, CMS Internet Only Medicare Managed Care Manual and NCQA's Special Needs Plans Structure and Process Guidelines.

The Care Coordination Team collaborates with multiple internal and external sources to develop an individualized care plan for the Member. The Care Coordination Team may work with the Social Worker to obtain resources for the member and caregiver. Routine rounds are held with the Medical Director to discuss medical care needs and concerns. Pharmacy and Behavioral Health clinicians are also utilized for consultation according to the Member's needs.

The coordination of members' care is essential for healthy outcomes. If you are the Primary Care Provider (PCP), remember to ask the member if they have been seen by any other providers since they were last seen, encourage the member to discuss treatment plans received elsewhere as well as requesting the information from the other provider.

If you are the member's specialist or other treating provider, obtain the name of the member's PCP and share medical assessments, prescriptions, or treatment provided to the member's PCP.

D. Condition-Specific Management Programs

Condition-specific management programs involve the same concepts as case management; however, it is disease specific. It is a system of coordinated health care interventions and communications for the population's members with conditions in which patient self-care efforts are significant. These programs emphasize prevention of exacerbations and complications through education and monitoring, and evaluation of clinical outcomes on an ongoing basis with the goal of overall health.

The Condition Specific Management Program takes a holistic approach recognizing that members face a wide variety of healthcare issues and concerns. The Care Coordination team provides support across a broad spectrum of health conditions and needs to actively engage members in better management of their overall care.

The disease states managed within this program are coronary artery disease, diabetes, congestive heart failure, chronic obstructive pulmonary disease and asthma (subject to change based on analysis). The primary goal is to stabilize the member's health condition/disease and assist them with tools, education and care necessary for self-management. The program promotes member and caregiver's active participation in management of the disease process resulting in an increased knowledge of the disease process, prevention and treatment. Additionally, the member increases their knowledge of healthy lifestyle changes and co-morbid management. The treating physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the physician by reinforcing education, monitoring and reporting. Providers identifying members with these diagnoses are requested to contact Case Management for referral into the program.

E. Telemonitoring

The purpose of the telemonitoring program is to reduce condition exacerbation, and unnecessary emergency room visits, inpatient admissions, and readmissions. Telemonitoring for members with CHF includes monitoring daily weight gain due to fluid retention, and blood pressure and heart rate monitoring. Telemonitoring for members with COPD includes daily pulse oximetry readings and heart rate monitoring. This is a service provided for our most vulnerable members only. The Care Coordination team will work with the member and/or caregiver for setup and training on telemonitoring equipment and will monitoring daily measures.

F. Complex Case Management

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Complex Case Management. Complex and catastrophic conditions such as multiple chronic conditions, trauma, AIDS, extensive burns, frequent emergency department utilization, and frequent inpatient admissions are intensively

managed by continually assessing, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the member are met.

The Care Coordination Team works with the member, treating practitioners, family members, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the member's progress and facilitate referrals to a less intensive health management program.

G. Transplant Case Management

Transplant Care Management focuses on the entire spectrum of transplant care. The care of the member is managed from time of the evaluation for a transplant until services are no longer needed. BCPTN helps its members in need of stem cell or solid organ transplants receive quality care by directing them to national transplant centers of excellence. The facilities within this network and the associated practitioners have been specifically selected for their expertise and quality outcomes in transplant cases.

Attention to assisting and educating the members about acquisition and use of needed drugs prescribed by their physician, with special emphasis on the Part B benefit for anti-rejection drugs is provided. It is critically important for the Care Coordination Team to be contacted as soon as the provider identifies the member may need an evaluation for transplant.

H. Contact/Referrals to Above Case Management Programs Information

Practitioners/providers are encouraged to initiate referrals for any of the health management programs by contacting BCPTN Case Management.

Phone: 1-877-715-9503

Fax: 1-866-325-6694

Referral requests should include the following information:

- Requesting provider's name and telephone number;
- Contact person and telephone number (if different from requesting provider);
- Member name;
- Member ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for referral; and
- Level of urgency.

One of our Care Coordination Team members, registered nurse, or behavioral health professional will contact the requesting provider upon receipt of the program referral.

I. Nursing Facility Diversion Program

BCPTN has a Nursing Facility Diversion Program to help allow these members to continue living safely in the community and to delay or prevent placement in a nursing facility. Through this program, our Care Coordination Team will coordinate with Medicaid Managed Care Organizations to facilitate home and community-based services for members who would otherwise qualify for nursing home placement.

Through case management activities, our Care Coordination Team identifies "at risk" members for nursing home placement by assessing to determine if a member has one or more of the following on an ongoing basis:

- Transfer – incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided 4 or more days per week
- Mobility – requires physical assistance 4 or more days per week. Mobility is defined as the ability to walk, use mobility aids such as a walker, crutch or can or the ability to use a wheelchair if walking is not feasible
- Eating – requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth
- Toileting – requires physical assistance to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care 4 or more days per week
- Expressive and Receptive Communication – incapable of reliably communicating basic needs and wants, such as the need for assistance with toileting or the presence of pain, using verbal or written language or the member is incapable of understanding and following very simple instructions and commands such as dressing or bathing without continual intervention
- Orientation – disoriented to person or place
- Medication Administration – not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance such as reminders when to take medications, encouragement to take medication, reading medication labels, opening bottles, handing to the member and reassurance of correct dose
- Behavior – requires persistent intervention due to an established and persistent pattern of dementia-related behavioral problems such as aggressive physical behavior, disrobing or repetitive elopement
- Skilled Nursing or Rehabilitative Services – requires certain daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than, for practical purposes, would be provided through a daily home health visit

Our case managers conduct thorough assessments of members' functional and cognitive status as well as social supports, home environment, financial status and medication administration abilities. Close monitoring of transition of care activities is crucial in preventing unnecessary nursing facility stays. Community resources are essential in keeping a member in the community as well as ongoing assessment of the caregiver to determine efficacy for managing the member's home needs.

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X. Utilization Management

A. Utilization Management Guidelines

BCPTN's Utilization management (UM) Program is committed to providing cost-effective healthcare services to its members. The UM program is designed to manage, evaluate, and improve the quality, appropriateness, and accessibility of healthcare services while achieving member and provider satisfaction.

BCPTN adheres to CMS' Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' Internet Only Managed Care Manual 100-16 Part C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance. CMS' requirements for Medicare Part C vary from the requirements for Original Medicare.

These utilization management strategies are additional effective mechanisms for identifying members who may benefit from Case Management. The Utilization Management program follows the CMS hierarchy for both decisions and references in making Medical Necessity determinations.

BCPTN coverage and payment is contingent upon the following:

1. A service must be a covered benefit in a member's Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BCPTN uses the following hierarchy of references to determine coverage:

- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476);
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare's Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare's Internet Only Manuals;
- Local Coverage Determinations (LCDs);
 - Coverage guidelines in Interpretive Manuals (Medicare's Internet Only Manuals, sub-manuals) including:
 - Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
 - MCG criteria;
 - BlueCross Utilization Guidelines;
 - U.S. Food and Drug Administration approved indications for medications;
 - Supplemental benefits and limitations as outlined in a member's Evidence of Coverage;
 - BCBST Policy; and
 - Other major payer policy and peer reviewed literature.

****Note: MCG is used as a guide in conjunction with clinical practice guidelines and clinical judgement.**

Services or items non-covered by Medicare may be covered by Medicaid depending on member plan and benefits. Please refer to BlueCare Tennessee's Provider Administration Manual for Medicaid coverage guidelines for fully integrated dual eligible members (members in BlueCare Plus and BlueCare Plus Choice plans) located at:

[Manuals, Policies & Guidelines | BCBS of Tennessee](#)

Behavioral Health Services provided by an Institution, physician, or other providers that are required to identify or treat a TennCare Enrollee's illness or disease should be ordered/recommended by a licensed physician or other licensed health care provider practicing within the scope of his or her license who is treating the member. The order/recommendation may be found in various locations in the record, such as a referral from the higher level of care, in the recommendations on the intake, or on the treatment plan as applicable for the service.

BCPTN's UM decision-making is based only on appropriateness of care and service and existence of coverage. The Organization does not reward practitioners or other individuals for issuing denials of coverage of care and financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided, and monitored by our Medical Director who actively seeks input from network-participating practitioners and other regulatory agencies.

B. Organization Determination

As it relates to UM processes, CMS defines an organization determination as a decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug. Organization determinations include:

- Advance/prior authorization determinations (prospective)
- Concurrent determinations
- Retrospective review determinations

C. Advance Determination

A member or provider can seek a determination of coverage of services *that do not require prior authorization* before receiving or providing services by requesting an Advance Determination. Claims submitted for services may be reviewed retrospectively for medical appropriateness to determine coverage and reimbursement. Providers can request an Advance Determination electronically or by phone or fax.

D. Prior Authorization

Participating providers are responsible for obtaining the appropriate prior authorizations/advance determinations. Members or their representatives may also request authorizations or advance determinations. It is not the member's responsibility for obtaining prior authorization determinations.

If the provider chooses to render services that require a prior authorization without obtaining a prior authorization, or that do not meet Medical Necessity criteria according to BCPTN's Clinical Decision Process, the member is not financially liable for the charges.

A list of items and services requiring prior authorization can be found on the BlueCare Plus TN website at [MA Master Prior Authorization List.pdf](#). Additionally, prior authorization for coverage and Medical Necessity for BCPTN members is required for (list is not all-inclusive):

- All acute care facility, skilled nursing facility and rehabilitation facility inpatient admissions
- Mental health acute inpatient admissions
- Substance Use Disorder inpatient admissions
- High tech imaging
- Non-emergent out-of-network services

- Non-preferred brands of diabetic testing supplies and over CMS allowable amounts of testing supplies
- Non-emergency ambulance transportation
- Psychiatric Partial Hospitalization Program (PHP) (excludes substance use disorder PHP which no longer requires prior authorization)
- Transcranial Magnetic Services
- Proton beam therapy
- **All out-of-network coverage**

Additional prior authorization requirements for members of our BlueCare Plus or BlueCare Plus Choice plans include:

- Private Duty Nursing (Medicaid Benefit) may be available if a member:
 - Is ventilator dependent for at least twelve (12) hours each day with an invasive patient end of the circuit (i.e., tracheostomy); or
 - Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least twelve (12) hours each day in order to avoid or delay tracheostomy (requires medical review); or
 - Has a functioning tracheostomy requiring suctioning and need other specified types of nursing.
- Home Health Aide visits and services
- All services performed by a plastic specialist, including but not limited to:
 - Abdominoplasty/Panniculectomy
 - Blepharoplasty
 - Breast Reduction
 - Reconstructive Repair Pectus Excavatum
 - Vein Ligation
- All food supplements and substitutes, including formulas taken by mouth.
- Incontinence diaper supplies >200 per member per month

Observation stays require notification to the UM Department to support required TennCare reporting and initiate the transition of care process.

Vendor Authorization Partnerships

BlueCare Plus Tennessee partners with vendors to assist with handling the following services:

High-Tech Imaging and some cardiac diagnostic services

In addition to Medicare Medical Policies for some services, providers can review medical criteria online at: [RADMD | Clinical Guidelines & Other Resources](#)

Durable Medical Equipment authorizations starting April 2026.

Home Health Services (Skilled Nursing Visits and Home Therapies) starting March 2026

Post-Acute Care authorizations (Skilled Nursing Facilities , Long Term Acute Care Hospital, Inpatient Recovery Facilities)

Oncology related services (Oncology Part B drugs and Oncology related radiation therapy-Coming in 2026

Authorization requests can be initiated by phone, available from 8 a.m. to 8 p.m. ET, at **1-888-258-3864** and when prompted select the option for type of request to be directed to the

vendor, or online through Availity 24/7. Request for High-Tech Imaging can not be submitted via fax.

E. Prior Authorization Review

A member, designated member advocate, practitioner or facility may request a prior authorization review. However, it is ultimately the facility and practitioner's responsibility to contact BCPTN to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.

Scheduled admissions/services must be authorized at least twenty-four (24) hours prior to admission. Authorization requests should be submitted as quickly as possible after a procedure is planned to keep in mind the CMS allowed timeframes for prior authorization determinations.

Prior authorization requests for emergency admissions must be submitted within twenty-four (24) hours or one (1) business day after services have started in order to facilitate referrals for transition of care.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and BCPTN participating providers will not be allowed to bill members for Covered Services rendered.

When a request for an authorization of a procedure, admission/service is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering the care for the day(s) or service(s) that have been denied. BCPTN's non-payment is applicable to both the facility and practitioner rendering the care. **Providers will not be reimbursed for inpatient level of care without an approved inpatient DRG on file.**

The practitioner and/or the facility are notified of determinations via telephone and/or electronically/fax and/or letter of the determination. Timeframes begin with receipt of the UM requests and include the issuance of the notification of the decision.

Nurse reviewers refer potential denials or questionable cases to a Medical Director for review. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the provider or member may appeal the decision.

Concurrent/extended stay reviews are performed for inpatient admissions for skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care facilities, and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request. It is acceptable to submit updates for concurrent review in increments of every 7 days.

Retrospective concurrent review is performed on outlier payments only for acute inpatient admissions. See Inpatient DRG Outlier Program Management section below for additional information.

BCPTN providers can submit authorization requests via telephone, facsimile or e-Health Services® via Availity, the secure area on the company website, www.bcbst.com. If you have

an urgent case in need of an urgent response that was submitted via the Availity platform, you must telephone the request to the Utilization Management Department at 866-789-6314 to notify us of the urgent status. A voicemail line will be available after business hours and on weekends/holidays for providers to contact BCPTN regarding concurrent or urgent information. Providers submitting requests via facsimile should utilize the authorization request form located on the company website at <https://provider.bcbst.com/tools-resources/documents-forms> and fax to 866-325-6698.

Medical Review Requirements

Requests requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day may be denied for lack of information. Covered Services that have not been authorized may not be billed to the member.

The following describes specific medical review guidelines:

1. Inpatient Admission

a. Acute Care Facility

All inpatient stays for planned procedures require prior authorization. Authorization will be issued when care and treatment are determined to be medically necessary and appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name.

Clinical information required for prior authorization:

- Procedure/operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs, imaging, and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications.

Inpatient DRG Outlier Program Management Program

Consistent with the criteria in MCG, we'll reimburse acute inpatient hospitalization days outside of the DRG approval as follows:

- MCG will be used with the concurrent information provided to determine if the care and services are consistent with an intensity of services that can only be safely and appropriately furnished in an acute inpatient setting. This review is performed by a Plan Medical Director. If criteria aren't met, the hospital day(s) may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after the DRG days have elapsed and are subject to the facility providing concurrent clinical information for review as contractually required. Please note that BCP DRGs are dollar threshold triggered, and any denied days will only apply to the outlier payment calculations (if applicable) and not to the base DRG payment due to the facility.
- Clinical information to support outlier payment is requested by sending the provider an Additional Documentation Request (ADR) letter. The supporting clinical can be submitted to the Plan by fax at the numbers provided in the letter. The providers have 45 days to submit the supporting clinical. Clinical that isn't submitted timely will result in the outlier payment being recouped. Any clinical received will be reviewed by the Plan Medical Director for medical necessity. The provider may follow the Provider Appeal process for any decisions with which they disagree.

Note: The member can't be held liable for payment of services received when not authorized.

Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Because of this, BCPTN has developed a readmissions program to more closely align with how CMS evaluates our Plan.

- i. 31-Day Readmission Quality Program
 - For purposes of this program, the date of discharge from the original acute inpatient admission (called the Index Admission) is the start of the 31-day window.
 - Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract are included in this program.
 - Readmissions in the 31-day window are understood to have a modifiable cause leading to the readmission. Because readmissions are a multi-stakeholder concern, the modifiable cause does not have to be related only to direct illness related complications, but also issues that arose from the discharge plan, such as but not limited to, the Member not receiving new prescriptions, home health not showing up timely at the Member's residence or lack of transportation to make outpatient appointments after discharge, etc.
 - All readmissions in this program are reviewed by a Plan Medical Director as part of a medical necessity review. This is not an automated claims-based adjudication. Thus, the provider has their normal medical necessity-based denial appeal rights.

- The facility reimbursement details of payment, see section XII Billing and reimbursement.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing admission for active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.
- Readmission(s) occurring within the original thirty-one (31) day window from the original index admission discharge will be bundled into the original admission if the above parameters are met. A new index readmission isn't set until a full thirty-one (31) days has elapsed.

Note: *The Member cannot be held liable for payment of services received when not authorized.*

ii. 48 Hour Readmission Quality Program

Medicare specifically identifies short term readmissions as a likely deviation in quality of care in the original discharge plan or discharges occurring before the member was stable for transition of care.

Therefore, we will not reimburse for a readmission within 48 hours from an index admission. This is not a matter of medical necessity. It is based on contract and payment. Our policy is as follows:

- For purposes of this program, the date of discharge from the original acute inpatient admission (called the Index Admission) is the start of the 48-hour window.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract, are included in this program.
- Because of the proximity to the index discharge, there is no modifiable cause component of this program.
- Also, because this readmission program has a contractual denial of the readmission, the Medical Necessity of the readmission is not evaluated.
- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay.
- The provider may file a provider appeal by following the steps in the denial letter.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing admission for active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.

Note: The member cannot be held liable for payment of services received when not authorized.

Lifetime Reserve Days

Members have 60 lifetime reserve days (LRD) available once the 90-day inpatient benefit has been exhausted. **The hospital is required to inform the member when they have used or will use their 90 days of benefits.** The member can elect not to use the LRD for all or part of a stay at any point during or after the stay. The hospital

should give notice when the member has **5 days** of the regular inpatient benefit remaining. Lifetime reserve days can be used only once in the member's lifetime.

b. Skilled Nursing Facility (SNF)

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional healthcare personnel. **BCPTN members do not require a 3-day inpatient acute hospitalization for SNF admission.**

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/facility's name, provider number and/or NPI, address, telephone number, caller's name;
- Initial review, concurrent review, or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.
- ****A Pre-Admission Screening and Resident Review (PASRR) is required for payment (regardless of payer) when a person is expected to admit to a Medicaid-certified facility.****

If a covered benefit, SNF admission may be approved for Members with all the following:

- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

Evaluation and Plan of Care

- Evaluation of the member must be submitted including the following as appropriate:

<ul style="list-style-type: none"> ➤ Primary diagnosis ➤ Ordering practitioner and date of last visit ➤ Date of diagnosis onset ➤ Baseline status 	<ul style="list-style-type: none"> ➤ Circulation and sensation ➤ Gait analysis ➤ Cooperation and comprehension ➤ Developmental delays
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- Current functional abilities
 - Functional potential
 - Strength
 - Range of Motion
 - Other therapies or treatments
 - Patient's goals
 - Medical compliance
 - Support system
- Plan of care must be submitted including the following as appropriate:
 - Short- and Long-term goals
 - Discharge goals
 - Measurable objectives
 - Functional objectives
 - Home program
 - Proposed admission date
 - Frequency of treatment
 - Specific modalities, therapy, exercise
 - Safety and preventive education
 - Community resources

Therapy Services

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy;
- Preventing complications and the start or revision of the member's maintenance therapy plan; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

Nursing Services

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Burns;
- Open lesions;
- Widespread skin disorder treatments;
- Initiation of and training for care of newly placed
- Tracheostomy
- Pain Management
- In-dwelling catheter with sterile irrigation and replacement
- Colostomy
- Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any Stage 3 or 4 pressure ulcer or 2 or more ulcers

Nursing and Therapy Services Not Requiring SNF Placement

Skilled nursing facility placement is not necessary for the services listed below. This list is not all- inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;

- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
- Invasive procedures (i.e., iontophoresis involving needle);
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

c. Rehabilitation Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for members meeting criteria.

Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the member's impairment.

Potential inpatient rehabilitation admissions include members with recent CVA, head trauma, multiple traumas, or spinal cord injury.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/facility's name, provider number and/or NPI, address, telephone number, caller's name;

- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for members with all the following:

- Rehabilitative potential, to include assessment and/or Current Functional Status from illness or injury and premorbid condition;
- Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 5-days-per-week, or therapy at least 15 hours per week (7 consecutive days);
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a practitioner with special training in the field of rehabilitation;
- A requirement for at least 2 therapies and a multidisciplinary team approach;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
- Acute medical condition stabilization
- Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

Evaluation and Plan of Care

- Evaluation of the member must be submitted including the following as appropriate:
 - Ordering practitioner and date of last visit
 - Primary diagnosis
 - Date of diagnosis onset
 - Baseline status
 - Current functional abilities
 - Functional potential
 - Gait analysis
 - Circulation and sensation
 - Cooperation and comprehension
 - Developmental delays
 - Other therapies or treatments
 - Patient's goals

- Strength
- Range of Motion
- Medical compliance
- Support system
- Plan of care must be submitted including the following as appropriate:
 - Short- and Long-term goals
 - Discharge goals
 - Measurable objectives
 - Functional objectives
 - Home program
 - Proposed admission date
 - Frequency of treatment
 - Specific modalities, therapy, exercise
 - Safety and preventive education
 - Community resources

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- **Compliance & participation with therapy**
- Demonstrating measurable practical improvement in function with evaluation of current level of functioning
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the member's condition)

Note: A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available on the BlueCross Provider page on the company website, [Provider Documents and Forms | BCBS of Tennessee \(bcbst.com\)](#)

Emergency Admission

In-network providers are responsible for contacting BCPTN within 24 hours or next business day.

Although emergency procedures do not require prior authorization, benefits are subject to verification for medical necessity and medical appropriateness and eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our website, www.bcbst.com, for registered users, fax, or contact the Utilization Management Department within 24 hours or next business day.

If the member is still admitted at that time, an admission review will be initiated. If the member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

Observation Stays

Observation for elective services, direct admissions from the physician's office, or a transfer from another facility require prior authorization. Observation stays through the Emergency Department do not require prior authorization but do require notification to the plan within 24 hours or next business day.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction, COPD exacerbation mostly resolved in the emergency department or w/in the first 24-48 hours, urinary tract infections in a geriatric patient without sepsis, and CHF needing mild diuresis, for example). Members in this status may advance to Inpatient admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission or within the next business day if unscheduled. For conversion to inpatient admission, submission of adequate clinical to determine Medical Necessity and Medical Appropriateness will be required.

Cosmetic Surgery

Cosmetic surgery is not a covered service. However, breast reconstructive and symmetry surgery following a mastectomy is a covered service.

Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.

Hospice Services

Hospice services are for terminally ill members where life expectancy is six (6) months or less and is covered by traditional Medicare.

Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in practitioners' offices. Providers may call Customer Service at the phone number listed on the Member's ID card to determine prior authorization requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Covered Services that have not been authorized may not be billed to the member if rendered by a BCPTN network provider.

Providers should call the BlueCross Provider Service line, 1-800-924-7141, or visit e-Health Services® on www.Availity.com to determine prior authorization requirements.

Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization. This authorization requirement applies to all provider types including home infusion therapy providers, specialty pharmacies, hospitals providing outpatient infusions, and injections.

If the provider is supplying a provider-administered drug that requires prior authorization, they must call BlueCross Utilization Management department at 1-800-924-7141 and choose the "Specialty Pharmacy" authorization option or submit the request via Availity, BCBST's secure portal on bcbst.com. We may request additional information if required to complete the review process.

Home Health Services

- Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the member's health or to facilitate treatment of the member's illness or injury. For the services to be covered, the member must have a medical condition that makes them unable to perform personal care and meet medical necessity and medical appropriateness criteria. Documentation must support the member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in the member's care. Home Health Services normally covered include, but aren't limited to:
 - Part-time intermittent Skilled Nursing Services
 - Medical Social Service
 - Home Infusion Therapy
 - Dietary guidance
 - Rehabilitative Therapies such as physical therapy, occupational therapy, etc.
- Home Health Services not normally covered include, but aren't limited to:
 - Routine transportation
 - Non-treatment services
 - Homemaker or housekeeping services
 - Behavioral counseling
 - Supportive environmental equipment
 - Maintenance or custodial care
 - Meal delivery
 - Personal hygiene
 - Convenience items
 - Home health aides
 - Private duty nursing
- For an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:
 - The member requires the skills of a nurse on an intermittent basis
 - The member has a condition that requires active skilled care
 - The services must be reasonable and necessary to the care of the condition
 - The member must be determined by us to be homebound during the episode of care
 - Documentation for prior authorization:
 - Practitioner's verbal or signed medical orders and plan of care for dates of service
 - Resumption of care (as appropriate)
 - Number of services requesting
 - Nurse's visit and progress notes
 - Therapist's visit and progress notes, if applicable
 - Availability of a caregiver Homebound status

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those that one would expect to be taught in the practitioner's office and the request must include the frequency and duration of services and must specify what services will be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.

*Note: Home aid services are available for those receiving skilled services for as long as the skilled services are being provided. Ongoing aid/non-skilled services may be covered under Medicaid or waiver programs as available.

Home Infusion Therapy

Home Infusion Therapy (HIT) is the administration of medications, nutrients, or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the Member's private residence. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

When an authorization is needed, specific information is required. Authorizations are valid for the dates approved; any break in service requires a new authorization. HIT providers requesting approval of HIT services should submit the following information:

- Member name, address, date of birth, sex, ID number;
- Practitioner name, address, phone number;
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams of protein for TPN;
- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner's verbal or signed medical order.

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the member, these services may require prior authorization under Home Health guidelines. If the HIT provider is dispensing the drug, they are required to follow BCPTN requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member's appropriate PBM.

Authorization decisions will be phoned, faxed, sent electronically, or mailed to the HIT provider, the prescribing Practitioner and member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

Durable Medical Equipment

Durable Medical Equipment (DME) purchases, rentals, or repairs may require prior authorization. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The member's diagnosis and supporting documentation should substantiate the need and use of the equipment in the medical record. Some items (such as CPAP and home ventilator) require a compliance report to show the member is using the equipment.
- Documentation of the member's capability to be trained in the appropriate use of the equipment.

- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10) months. DME specified per CMS to be rental items will not be approved for purchase except in rare circumstances.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reasonable useful lifetime (RUL) restrictions apply

Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Member's mobility or functional status if applicable to the item requested
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.
- Explanation of need for out-of-network supplier (as applicable).

The following guidelines apply to reimbursement for repair of DME equipment:

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BCPTN;
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs. BCPTN will only provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BCPTN will not provide benefits for Investigational Durable Medical Equipment.

Advanced Imaging/High Tech Imaging

Prior authorization* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our High Tech Imaging vendor on behalf of BCPTN. Prior authorization is not required for imaging procedures performed during an inpatient admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- | | |
|---|---|
| ➤ Computed tomography (CT) | ➤ Magnetic resonance angiography (MRA) |
| ➤ Computed tomography angiography (CTA) | ➤ Positron emission tomography (PET) |
| ➤ Magnetic resonance imaging (MRI) | ➤ Magnetic resonance spectroscopy (MRS) |

- Nuclear cardiology

To request prior authorization for any of the previously listed radiology procedures, call our High Tech Imaging vendor at 1-888-258-3864.

Second Surgical Opinion

BCPTN will pay for any second surgical opinion requested by a member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to Second Surgical Opinions:

- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BCPTN network.

Non-Emergent Air Ambulance Transportation

- Prior authorization is required for non-emergent air ambulance transportation.
- Prior authorization is NOT required for emergency air ambulance transportation (e.g., from the scene of an accident when ground transport is not appropriate or would pose a threat to the Member).
- To request prior authorization for non-emergent air transportation for a BCPTN member, call 1-800-299-1407 from 8 a.m. to 6 p.m. (ET).

Molecular and Genomic Testing

Prior authorization is required for select molecular and genomic testing.

Radiation Oncology

Prior authorization is required for oncology/radiation therapy procedures.

Investigational Services

Investigational services are those services that do not meet BlueCross BlueShield of Tennessee's definition of Medical Necessity. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee's Medical Policy Research & Development Department and are assessed using sources that rely upon evidence-based studies. If the FDA or CMS initially approves a procedure, device, or medication, it might still be considered experimental if there isn't enough peer-reviewed research proving it's safe and effective compared to existing treatments.

Providers can view the criteria used in making determinations as to whether a service is considered to be Investigational or Medically Necessary via the Medical Policy Manual in the Manuals, Policies and Guidelines section on the company website, <http://www.bcbst.com/bluecareplus.bcbst.com> (link to guidelines and policies at the bottom of the page) and are informed of new and revised medical policies via monthly BlueCross Provider e-mail notification message. Newly approved medical policies may be viewed on BlueCross' Upcoming Medical Policies web page located on the company website, www.bcbst.com.

Clinical Trials

In general, the routine costs of a clinical trial include those costs that a Medicare beneficiary would be eligible for if there were no clinical trial. This principle tries to ensure that Medicare beneficiaries are not penalized nor have items or services taken away from them if they participate in a qualifying clinical trial. These routine costs include:

- Items or services typically provided absent a clinical trial (e.g., conventional care);
- Items or services required solely for the provision of the investigational item or service;
- Clinically appropriate monitoring of the effects of the investigational item or service;
- Prevention of complications; and
- Items or services for reasonable and necessary care arising from the provision of an investigational item or service, especially for the diagnosis and treatment of complications,

Items and services not covered as "routine services" in a clinical trial include:

- The investigational item or service itself, unless otherwise covered outside the clinical trial;
- Items and services for the purpose of determining eligibility for the study not related to medically necessary clinical care;
- Items and services provided solely to satisfy data collection and not necessary for clinical management; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.
- The investigational items or services themselves are not covered as routine costs, unless those items or services are available to Medicare beneficiaries absent a clinical trial. For instance, if a qualifying clinical trial is studying a drug for a non-FDA approved indication, the drug is not covered because it is not otherwise available to Medicare beneficiaries for that experimental indication, even if the drug is FDA approved for other indications. Conversely, if an investigator is doing a head-to-head study of two standard-of-practice procedures to see which one is superior in a given circumstance, then the procedures under study are also covered, even though they are the "experimental service," because these services are otherwise covered for Medicare beneficiaries.

**Expenses related to clinical trials are covered under Traditional Medicare.

Medically Necessary and Medically Appropriate Policy

BCPTN covers Medically Necessary and Medically Appropriate healthcare services not otherwise excluded under BCPTN healthcare benefits plans.

Medically Necessary or Medical Necessity

"Medically Necessary" refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other healthcare provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature

generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

Medically Appropriate

“Medically Appropriate” refers to services, which have been determined by BCPTN in its discretion to be of value in the care of a specific member. To be Medically Appropriate, a service must meet all of the following:

1. Be Medically Necessary.
2. Be consistent with generally accepted standards of medical practice for the member’s medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the member’s medical condition.
4. Not be provided solely to improve a member’s condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the provider, member or member’s family.

BCPTN may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate.

Note: According to Contract, BCPTN Will Not Reimburse for Photocopying Expenses. BCPTN encourages open practitioner/patient communication regarding appropriate treatment alternatives.

F. UM Contact Information

Notification and authorization requests should be submitted to BCPTN.

Authorization, requests, advance determination requests, and observation notification may be submitted to BCPTN via the following methods:

Telephone: 1-866-789-6314
Online: <http://www.bcbst.com>
Fax: 1-866-325-6698

Mail:

BlueCare Plus Tennessee Utilization Management Department
One Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Fax forms are available on the BCPTN website at: <https://provider.bcbst.com/tools-resources/authorizations-appeals>

HH Aide and PDN Missed Visit Reminder (TennCare reporting)

Please send information on the HH Aide and PDN missed visit form located on the provider portal on the BCPTN website at : <https://provider.bcbst.com/tools-resources/documents-forms/>.

Refer to BlueCare Tennessee’s Provider Administration Manual for Medicaid Prior Authorization and Notification Request related to BCPTN Choice members located at: <https://bluecare.bcbst.com/providers/news-manuals>

G. CMS Guidance for Outreach to Support Coverage Decisions

CMS requires Medicare Advantage plans to conduct appropriate outreach to obtain the necessary clinical information in order to conduct a review for medical necessity and appropriateness. If clinical information is not adequate or a Medical Director has additional questions, BCPTN will follow this process:

- Conduct outreach 2 times (once by phone and an Intent to Deny fax with the invitation for a peer-to-peer) to obtain information. The medical director may also reach out to the ordering physician to obtain the needed clinical information.
- If information is received, it will be reviewed to determine medical necessity and appropriateness and an approval or denial will be issued as appropriate
- If information is not received after outreach notifying provider of intent to deny, the request will be reviewed by the Medical Director using the information available to BCPTN

All outreaches will be conducted within the appropriate review timeframes for standard preservice and expedited organization determinations described in section J.

H. Non-Compliance with Prior Authorization Requirements

A contracted provider is required by contract to follow utilization management processes and must obtain authorization prior to scheduled services or request authorization in the timeframes described above for unplanned services. Failure to comply within specified authorization timeframes will result in a contractual “non-compliant” denial. A request for authorization will not be reviewed if the request is “non-compliant” unless:

- A member does not provide the provider with BCPTN identification card nor notify the provider he or she has a BCPTN plan; or
- BCPTN has not issued a coverage identification card prior to a member needing a service; or
- A coverage issue existed.

If one of the above situations occurred and a provider can provide written evidence of this, a provider can request an appeal through the Provider Dispute Resolution Procedure (PDRP) including a copy of the medical record relevant to the admission or services and the face sheet at the time of the service. At that point, a medical necessity review will be conducted. The PDRP is further described in section L.

BCPTN providers cannot bill members for covered services denied due to non-compliance by the provider.

I. Retrospective Review

Prior to claims payment, select codes may require a review for medical necessity. These reviews will be performed using CMS’ hierarchy or TennCare’s hierarchy and an approval or denial of medical necessity will be issued.

J. Review Timeframes

Organization determinations are reviewed as expeditiously as a member’s health condition requires, but not later than the below timeframes.

Organization determination types:

Standard preservice organization determination – A determination will be made no later than seven (7) calendar days of receipt of request.

Standard preservice organization determination for Part B drugs – A determination will be made no later than 72 hours of receipt of request.

Expedited organization determination – Upon request by a physician, member or member's authorized representative a determination will be made within 72 hours of receipt of request once received into the reviewing area. This does not apply to services already rendered – those type requests will be handled as a standard organization determination or retrospective organization determination as applicable. **An expedited organization determination is for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with [§§ 422.570](#) and [422.572](#)

Expedited organization determination for Part B drugs – Upon request by a physician, member or member's authorized representative a determination will be made within 24 hours of receipt of request. This does not apply to services already rendered – those type requests will be handled as a standard organization determination, or retrospective organization determination as applicable. **An expedited organization determination is for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with [§§ 422.570](#) and [422.572](#).

Excluding Part B drugs, both standard and expedited review requests may be extended up to fourteen (14) calendar days if a member requests and extension or if BCPTN justifies a need for additional information and that it is in the interest of the member to extend the timeframe.

Retrospective organization determinations – within thirty (30) calendar days of receipt of request

K. Mandated Notices

A. Important Message from Medicare (IM):

Hospitals are responsible to deliver the Important Message from Medicare (IM) to any BCPTN member who is a hospital inpatient to inform a member of hospital discharge appeal rights.

CMS requires within two (2) calendar days of admission to a hospital to:

- Issue IM to member or member's authorized representative
- Explain a member's right as a hospital patient including discharge appeal rights
- Obtain signature of member or authorized representative and provide a copy to the member/representative

CMS requires within two (2) calendar days of discharge to a hospital to:

- Deliver a copy of the signed notice to the member/representative

B. Detailed Notice of Discharge (DN):

CMS requires a Detailed Notice of Discharge (DN) be distributed to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BCPTN no longer intends to continue coverage of an authorized hospital inpatient admission. BCPTN delegates to providers the responsibility for developing and delivering the DN for provider discharge determinations and for delivery of DN for BCPTN discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO's notification or BCPTN's request for delivery. Providers are required to fax a signed copy of the DN to HMO D-SNP Plus UM Department at 1-866-789-6314. Providers must be able to

demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.

C. Notice of Medicare Non-Coverage (NOMNC):

Notice of Medicare Non-Coverage: Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Medicare Notices of Non-Coverage (NOMNC) to the member or the authorized member representative in accordance with applicable CMS regulations. Per CMS regulations, HHAs are responsible for both completing the NOMNC form and issuing this to the member or authorized representative.

CMS requires the NOMNC be delivered at least two days prior to the member's HHA, SNF, or CORF authorized services ending. **Days won't be extended due to untimely delivery of the NOMNC by the facility.** If the member's services are expected to be fewer than two days, the HHA, SNF or CORF must provide the NOMNC to the member at the time of admission to the provider. The signed NOMNC must be faxed to BlueCare Plus no later than noon the day following receipt of the NOMNC. **Facilities/agencies can provide a NOMNC independent of the health plan.** A model NOMNC form can be found at The CMS Website. Providers are required to fax a signed copy of the NOMNC to BCPTN UM Department at 1-866 325-6698. It is the responsibility of the Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) to provide requested documentation to the Quality Improvement Organization if an appeal is requested by the member.

D. Detailed Explanation of Non-Coverage (DENC):

CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF when BCPTN no longer intends to continue coverage. BCPTN delegates to providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BCPTN discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO's notification or BCPTN' request for delivery. Providers are required to fax a signed copy of the DENC to BCPTN UM Department at 1-866 325-6698. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform BCPTN members that a request for denial notice must be submitted to BCPTN by the member, in the event that the member believes that he/she is being denied service.

E. Medicare Outpatient Observation Notice (MOON)

Hospitals and critical access hospitals are required to provide a MOON to Medicare Advantage beneficiaries receiving observation services for more than 24 hours to inform them they are outpatients receiving observation services and are not patients of a hospital or critical access hospital.

- Written MOON must be provided no later than 36 hours after observations services an outpatient began
- Oral notification must consist of an explanation of the MOON
- Member or authorized representative must sign and date the MOON

L. Provider Appeal

This section applies to the provider appeal process for utilization management review of a denied authorization request for medical necessity. The Provider Dispute Resolution Procedure (PDRP) for claims payment is explained in section XIV – B.

Peer-to-Peer and Re-Evaluation Processes

In accordance with guidance from CMS and our accreditation through the Utilization Review Accreditation Commission (URAC) the following peer-to-peer and appeal processes are applicable for our MA products.

A Peer to Peer (P2P) conversation is not an appeal, not specialty matched, and not always intended to overturn a denial. However, it is an opportunity for the requesting physician to share critical clinical information that may have been omitted from the original request for services. For Medicare Advantage (MA) plans, discussion must be completed prior to the adverse determination being rendered or after the item/service has been provided to the member (i.e. after discharge). Once an adverse determination has been made for pre-service or concurrent cases, participating providers are able to submit a dispute under the appropriate Appeal process. Peer-to-peer discussions are not available following appeals requests or determinations.

When there's insufficient clinical documentation to support an initial organization determination, clinical information is requested a minimum of two times using at least two different notification methods including a fax offering a peer-to-peer pre-decision. The Plan Medical Director may make an additional outreach directly to the requesting physician to perform a peer-to-peer discussion. If we still don't receive the needed clinical information within one business day, we'll issue the adverse determination for insufficient clinical documentation. There's no additional peer-to-peer options for the requesting physician on this specific request. For documents submitted after the determination, outreach to the submitting provider will be completed to determine the intent of the additional documents.

Concurrent Inpatient Review – An adverse determination for inpatient days coverage will be treated as a member appeal if the member is still confined on inpatient status. An adverse determination for dates which have already occurred, and the member has discharged will be treated as a provider appeal.

When an adverse organization determination is rendered and there's sufficient clinical information, the requesting provider can submit a dispute under the appropriate Appeal process. If the services haven't yet been rendered or if the member has additional financial responsibility from an adverse determination, the additional information will be reviewed under the member appeal process.

An adverse determination for ancillary services (Home Health, DME, outpatient/home health therapies), pre-service or from current date forward requesting an organization determination will be treated as a member appeal.

When requests are classified as member appeals, only the member and treating physician acting on the behalf of the member have appeal rights per CMS regulations. Anyone else needs to submit an Appointment of Representative (AOR) form on file before the appeal can be reviewed. This includes third-party companies acting on behalf of a facility for adverse determinations appealed while the member is still in the hospital.

When services were already rendered and there was no additional member financial responsibility, these will be processed as provider appeals. In the instance where a P2P is eligible, one (1) peer-to-peer conversation and one (1) level of provider written appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the member was discharged from the hospital. A peer-to-peer request must be requested within ten (10) business days from the member's discharge. A peer-to-peer won't be scheduled if a written appeal has been submitted concurrently.

Concurrent Inpatient Review (SNF/IRF/LTACH) – An adverse determination for inpatient days coverage while the member is still confined on inpatient status will be treated as a member appeal. An adverse determination for dates which have already occurred, and the member has discharged will be treated as a provider appeal as this is a post-service appeal for payment.

When an adverse Organization Determination is rendered and there is sufficient clinical information, the requesting provider can request a peer-to-peer discussion with a Medical Director for post-service denials only within ten (10) business days of discharge. Alternately, the requesting provider can submit additional clinical documentation relative to the basis for the original denial. If the services have not yet been rendered or if the member has additional financial responsibility from an adverse determination and additional information is received, a phone outreach will be made to determine the intent of the additional clinical. If the intent is to appeal the decision, instruction will be provided to the provider how to request a member appeal.

A peer-to-peer is not available for denials due to noncompliance, readmission quality program or for benefit exhaustion as this was not a decision based on medical necessity. Providers should submit documentation and a provider appeal request if they believe the plan made a mistake regarding noncompliance or benefit exhaustion.

An adverse determination for Ancillary Services (Home Health, DME, outpatient/HH therapies), pre-service or from current date forward requesting an appeal will be considered as a member appeal. An adverse determination for dates which have already occurred will be considered as a provider appeal. Providers can also request a peer-to-peer discussion with a plan Medical Director on adverse decisions as they related to post-service denials.

The Utilization Management Department makes every attempt to review provider appeals that are received from the provider within 60 calendar days of the provider's receipt of a denial. Mail provider appeal requests to:

BCPTN Utilization Management Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Or fax to: 866-325-6698

M. Reopening

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows on its face that an obvious

error was made at the time of the determination or decision. BCPTN has the authority to determine if a request will be reopened.

The following are guidelines for a reopening request:

- May be made verbally or in writing;
- Should include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and
- Must be made within the timeframes permitted for reopening.

Additional information related to reopening can be found in CMS' Part C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance.

Medical Policy Manual

The Medical Policy Manual contains medical policies approved by BlueCross BlueShield of Tennessee. Medical policies address specific new medical technologies or pharmaceutical agents.

Medical policies are based upon evidence-based research using published studies and/or prevailing Tennessee practice. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered Medically Necessary, Not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company website at <https://provider.bcbst.com/tools-resources/manuals-policies-guidelines>.

Many policies also contain a Medical Appropriateness section. This section contains the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

Medical Policy Appeals

BlueCross BlueShield of Tennessee network providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the Investigational status of a medical policy, or the Medical Appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing providers position must be submitted with each medical policy appeal.

The medical policy appeal process of an active medical policy:

- Provider submits a written request for appeal of a medical policy, along with full-text copies of supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.

- Medical Policy Research & Development Department reviews the appeal and supporting documentation.
- The appeal decision is returned to the Provider Appeals Department with a detailed response for the provider.
- A written response is sent via registered mail to the network provider.
- Network providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator Provider Network Management BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402, 0039

Administrative Services Policies

Administrative Services Policies contain corporate positions and/or criteria that reflect BCBST business decisions. These documents are often associated with a Member's benefit plan (i.e., Evidence of Coverage) and they may be used in the adjudication of claims and requests for medical, dental, vision and/or pharmacy related services. Providers may view BCPTN Administrative Services Policies on the company website at <https://provider.bcbst.com/tools-resources/manuals-policies-guidelines>.

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XI. Quality Improvement Program



The BCPTN Quality Improvement Program provides the framework for the evaluation of the delivery of healthcare services and other services provided to members. The QI Program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of care and service provided to BCPTN members. The QI Program is a three-tiered system of performance improvement that meets the following criteria:

Tier one consists of data for quality and health outcomes that are collected and analyzed to allow beneficiaries to compare and select from the available health coverage options. The data includes selected HEDIS® measures, STARs measures,

Satisfaction measures, and other structure and process measures. Each year, CMS provides guidance on HEDIS and STARs measures that health plans are required to report on for the contract year.

Tier two is made up of collection, analysis, and reporting data that measure the performance of the SNP Model of Care (MOC).

Tier three consists of monitoring of the implementation of care management through the collection and analysis of selected data that measure the effectiveness of SNP MOCs.

BCPTN must provide for the collection, analysis, and reporting of data that measure health outcomes and indices of quality pertaining to the dually eligible members special needs population.

A. HEDIS Measures

The Medicare Advantage (MA) / Part D Contract and Enrollment Data section serves as a centralized repository for publicly available data on contracts and plans, enrollment numbers, service area data, and contact information for MA, Prescription Drug Plan (PDP), cost, Program of All-inclusive Care for the Elderly (PACE), and demonstration organizations.

HEDIS® is a product of NCQA. MAOs meeting CMS's minimum enrollment requirements must submit audited summary-level HEDIS® data to NCQA. Contracts with 1,000 or more members enrolled as reported in the July Monthly Enrollment by Contract Report (which can be found at <http://www.cms.hhs.gov/MCRAAdvPartDENrolData/MEC/list.asp#TopOfPage>).

BCPTN must collect and submit HEDIS® data to CMS. Closed cost contracts are required to report HEDIS® as long as they meet the enrollment threshold in the reporting year. Patient-level data must be reported to the CMS designated data contractor. Information about HEDIS® reporting requirements is posted on the HPMS webpage. During the contract year, if an HPMS contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS® data for all members of the contracts involved. If a contract status is listed as a conversion in the data year, the contract must report if the new organization type is required to report.

CMS collects audited data from all benefit packages designated as SNPs and contracts with ESRD Demonstration Plans that had 30 or more members enrolled as reported in the SNP Comprehensive Report (which can be found at

<http://www.cms.hhs.gov/MCRAAdvPartDENrolData/SNP/list.asp#TopOfPage>).

The data collection methodologies for HEDIS® are either the administrative or the hybrid types. The administrative method is from transactional data for the eligible populations and the hybrid method is from medical record or electronic medical record and transactional data for the sample.

B. Consumer Assessment of Health Providers and Systems (CAHPS)

The CAHPS survey is a CMS driven member survey evaluating multiple areas that impact members including provider encounters. The CAHPS survey collects information on the quality of health services provided by insurance plans. Consumer evaluations of health care and prescription drug services, such as those collected through the CAHPS surveys, measure important aspects of a patient's experience that cannot be assessed by other means.

CMS offers a listing of reports from the annual CAHPS surveys on its website at:

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS>.

The CAHPS Module divides the following sections based on the various CAHPS surveys CMS sponsors:

- Fee for Service CAHPS (FFS CAHPS)
- Hospital CAHPS (H CAHPS)
- In Center Hemodialysis CAHPS (ICH CAHPS)
- Medicare Advantage CAHPS (MA CAHPS)
- Nursing Home CAHPS (NH CAHPS)

C. STARS

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system including providers in the healthcare system. The rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) and prescription drug plans (PDP). **BCPTN is a 3.5-STAR plan.**

The program is a key component in financing health care benefits for MA plan members. In addition, the ratings are posted on the CMS consumer website, <https://www.medicare.gov>, to provide information for beneficiaries choosing an MA plan in their area.

STARS will help promote quality improvement and performance measures. These ratings strengthen beneficiary protections and allow CMS to distinguish stronger health plans and remove consistently poor performers.

How are Star Ratings Derived?

Health plans are rated based on measures in five categories:

- Members' compliance with preventive care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

Benefits to Providers

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

Benefits to Members

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care
- Matches their individual needs

BCPTN is strongly committed to providing high-quality Medicare health coverage that meets or exceeds all CMS quality benchmarks. The structure and operations of the CMS Stars rating system will ensure that resources are used to protect, or in some cases, to increase benefits and keep member premiums low. BCPTN encourages members to become engaged in their preventive and chronic-care management through outreach and screening opportunities. Providers are an important partner in these efforts.

TIPS FOR PROVIDERS

- Encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify patients that appear to be non-adherent at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to BCPTN and/or BCPTN Quality Care Rewards portal.
- Communicate clearly and thoroughly; ask:
 - What questions do you have?
 - Have you seen a specialist or been an inpatient in the hospital since your last visit?
 - Have you been in the emergency room since your last visit?
 - May we review your current medications?
- Understand each measure you as a provider impact.
- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to identify opportunities for you or your office to have an impact:
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS>

CMS has created the **Health & Drug Plan Quality and Performance Ratings 2026 Part C & Part D Technical Notes**, to review this document in its entirety follow this link: [2026-star-ratings-technical-notes.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS)

This document describes the methodology for creating the Part C and D Plan Ratings displayed in the Medicare Plan Finder (MPF) tool on <http://www.medicare.gov/>. These ratings are displayed in the Health Plan Management System (HPMS) for contracts and sponsors. In the HPMS Quality and Performance section, the Part C data can be found in the Part C Performance Metrics module in the Part C Report Card Master Table section. The Part D data are located in the Part D Performance Metrics and Report module in the Part D Report Card Master Table section. All of the health/drug plan quality and performance measure data

described in the document are reported at the contract level. Table 1 lists the contract year 2023 organization types and whether they are included in the Part C and/or Part D Plan Ratings.

The Plan Ratings strategy is consistent with CMS 'Three-Part Aim (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

- Outcomes: Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
- Intermediate outcomes: Intermediate outcome measures help move closer to true outcome measures. Controlling Blood Pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for members with hypertension.
- Patient experience: Patient experience measures represent members' perspectives about the care they have received.
- Access: Access measures reflect issues that may create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
- Process: Process measures capture the method by which health care is provided.

D. Quality Incentive Program

BCPTN offers primary care providers a Quality Incentive Program which includes variable reimbursement for closing specific quality gaps in care linked to the CMS STAR program for Medicare Advantage plans, completion of the provider Model of Care training, and returning defined medical records during the performance year. Providers who are participating in this program have a quality contract amendment outlining how the results impact your base reimbursement.

For performance year 2026, the quality measures included in the Quality Incentive Program are:

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2026 Calendar Year

Dual Special Needs D-SNP Program Measures

Measure Name	Measure Type	Weight	Member Gift Card Available*
Glycemic Status Assessment for Patients with Diabetes (GSD)	Outcome	3	—
Controlling High Blood Pressure (CBP)	Outcome	3	—
Plan All-Cause Readmissions (PCR)	Outcome	1	—
Breast Cancer Screening (BCS)	Process	1	\$25
Care for Older Adults (COA) - Medication Review	Process	1	—
Care for Older Adults (COA) - Functional Status Assessment	Process	1	—
Colorectal Cancer Screening (COL)	Process	1	\$15, \$50
Kidney Health Evaluation for Patients With Diabetes (KED)	Process	1	—
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	Process	1	—
Medication Adherence for Cholesterol (Statins)	Outcome	1	—
Medication Adherence for Hypertension (RASA)	Outcome	1	—
Medication Adherence for Diabetes Medications (OAD)	Outcome	1	—
Member Experience (CAHPS): Care Coordination	HMS Mock Member Survey	2	—
Member Experience (HOS): Improving or Maintaining Physical Health	HMS Mock Member Survey	2	—
Statin Use in Persons with Diabetes (SUPD)	Process	1	—
Transitions of Care (TRC)	Process	1	—
Measures for Display/Monitoring Status Only			
Annual Wellness Visit (AWV)	Process	0	\$50
Concurrent Use of Opioids and Benzodiazepines (COB)	Outcome	0	—
Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)	Outcome	0	—
Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)	Outcome	0	—
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Process	0	—

Detailed information related to each quality measure can be found in the 2026 Quality Program Information Guide located on our website at: [https://www.bcbst.com/docs/providers/quality-initiatives/Quality Partnerships Program Guide.pdf](https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf).

E. Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the first outcomes measure used in Medicare managed care and the largest survey effort ever undertaken by the Centers for Medicare & Medicaid Services (CMS). The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. Managed care plans with Medicare Advantage (MA) contracts must participate. CMS has provided a website for review located at www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html. This website is designed to provide current information on the progress of the HOS program, as well as house the full spectrum of Medicare HOS related data and reports.

The Veterans RAND 12-Item Health Survey (VR-12), supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS® functional status measure, HOS. This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, the results are primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that BCPTN currently uses for clinical quality improvement.

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XII. Billing and Reimbursement

A. Claims Processing

BCPTN electronic claims processing system is in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. Business edits have been modified to recognize the new ANSI formats. These edits apply to both electronic and scannable paper claims.

BCPTN providers contracted with Medicare and Medicaid lines of business, serving the BCPTN members will be able to take advantage of single-claim submissions. Claims submitted to BCPTN for BlueCare Plus and BlueCare Plus Choice will be processed under both Medicare and Medicaid benefits through BCPTN. Claims for BlueCare Plus Select will be processed under Medicare benefits through BCPTN. For Medicaid benefits to be considered, the provider must submit the claim to the member's assigned MCO.

Provider Number for Electronic Claims

Claims submitted electronically must include the provider's appropriate National Provider Identifier (NPI), and the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at <http://www.wpc-edi.com>. Additional companion documents needed for BCPTN electronic claims submission can be accessed at <http://www.bcbst.com/providers/ecommm/technical-information.shtml>.

1. Electronic Enrollment and Support

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, provider number, NPI, name), or any changes of software vendor should be communicated to e-Commerce via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded at www.bcbst.com or obtained upon request. Failure to submit a Provider Electronic Profile form when changes to electronic submission information occur can result in delays in claims payment or disruption of electronic claims submissions. Mail or Fax Provider Electronic Profile forms to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Services
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN 37402-0007
Fax 423-535-7523

For technical support or enrollment information, call, fax, or e-mail:

Technical Support	call:	423-535-5717
	fax:	423-535-1922
	e-mail:	www.ecomm_support@bcbst.com
Enrollment	call:	1-800-924-7141
	fax:	423-535-7523
	e-mail:	www.ecomm_contracts@bcbst.com

2. Electronic Data Interchange (EDI)

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BCPTN uses the ANSI 837 version, 5010 format. American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

3. Secure File Gateway (SFG)

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BlueCross BlueShield of Tennessee using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

Protocol	Description
TTPS Website, https://mftweb.bcbst.com/myfilegateway	The BlueCross BlueShield of Tennessee secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.
SFTP (server mftsfpt.bcbst.com)	The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.
FTP/SSL (server mftsfpt.bcbst.com)	The BlueCross BlueShield of Tennessee FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.

4. ANSI 837 (Version 5010)

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. *Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the [Washington Publishing Company](#) website at Additional companion documents needed for BCPTN electronic claims submission can be accessed at [eBusiness Technical](#) page or the [eBusiness User Guide](#) for additional information.

5. Submission of Paper Claims

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication.

This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Key advantages to submitting electronically are:

- Earlier payments;
- More secure submission process;
- Reduced administrative costs
- Less paper storage.

More information regarding submitting electronic claims can be found on the [Providers Resource](#) page on the BCPTN Website. For assistance with Availity, please contact eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6:00 p.m., Friday 9 a.m. to 6:00 p.m. (ET), or via e-mail at eBusiness_Service@bcbst.com.

6. Corrected Bills

Corrected Electronic Claims (Required Method)

If a claim is denied on a remittance advice, it requires correction and resubmission electronically. Corrected Bills for Institutional and Professional claims can be filed electronically in the ANSI-837, version 5010 format. Electronic and paper corrected claims that don't follow the billing guidelines outlined below will be denied as duplicate submissions. These guidelines also apply when submitting a correction to an Explanation of Benefits (EOB) form. The associated claim should be submitted as described above to prevent claims denial.

The following guidelines are based on National Implementation Guides found at <http://www.wpc-edi.com> and BlueCare Tennessee /BCBST Companion Documents found at: <http://www.bcbst.com/providers/ecommm/technical-information.shtml>

ANSI-837P – (Professional) and ANSI-837I – (Institutional)

In most instances, claims correction should be submitted in an electronic format.

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:
 - "7" – REPLACEMENT (Replacement of Prior Claim)
 - "8" – VOID (Void/Cancel of Prior Claim)
2. In the 2300 Loop, the REF segment (claim information), must include the original claim number for the claim being corrected. The original claim number can be found on the electronic remittance advice. If an invalid original claim number is submitted, the corrected claim may be denied.
 - REF01 must contain 'F8'
 - REF02 must contain the original BCBST claim number

Example: REF*F8*1234567890~
3. In the 2300 Loop, the NTE segment (free-form 'Claim Note'), must include the explanation for the Corrected/Replacement Claim.
 - NTE01 must contain 'ADD'

- NTE02 must contain the free-form note indicating the reason for the corrected/replacement

Example: NTE*ADD*CORRECTED PROCEDURE CODE ON LINE 3

For Technical Support assistance, contact eBusiness Technical Support at 423-535-5717 (Option 2) or via e-mail at Ecomm_TechSupport@bcbst.com. Technical support is available Monday through Thursday, 8 a.m. to 5:15 p.m. (ET), and Friday, 9 a.m. to 5:15 p.m. (ET).

Corrected Paper Claims - Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Submit a new claim form with the correct data as follows:

- **CMS-1500 Claim Form**
 - Submit a Frequency Code “7” (**Replacement of prior claim**) or “8” (**Void/Cancel of prior claim**) in the “**Resubmission Code**” field of Block 22.
 - The claim number originally used by BCPTN to process the claim should be included in the “**Original Ref. No.**” field of Block 22. If an invalid original claim number is submitted, the corrected bill may be denied.
 - Failure to include the appropriate “**Resubmission Code**” and “**Original Ref. No.**” in Block 22 may result in a claim rejection or denial.
- **CMS-1450 Claim Form**
 - Submit a Frequency Code “7” (**Replacement of prior claim**) or “8” (**Void/Cancel of prior claim**) as the fourth digit in the “**Type of Bill**” field (FL 4).
 - The claim number originally used by BCPTN to process the claim should be include in the “**Document Control Number**” (**DCN**) field (FL 64).
 - Failure to include the appropriate “**Frequency Code**” in FL 4 and “**Document Control Number** (**DCN**)” in FL 64 may result in a claim rejection or denial.

7. Timely Filing Guidelines

Contracted and non-contracted providers must submit all claims for medical services within one (1) year of the date of service or from the date of discharge.

The provider has two (2) years from the end of the year in which the claim was originally submitted to file a corrected claim.

BCPTN will not be obligated to pay such claims filed after expiration of the applicable time period, and such claims shall not be billed to the BCPTN member. BCPTN will process in the normal course of its business all claims submitted by the Physician/Supplier.

BCPTN generates the 277 Health Care Information Status Notification report as proof of timely filing for electronically submitted BCPTN claims. The electronic claims 277CA Health Care Information Status Notification supplies providers with one comprehensive report of all claims received electronically. This report should be maintained by the provider/supplier for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8:00 a.m. to 6:00 p.m. (ET), Friday 9:00 a.m. to 6:00 p.m. (ET), or email at eBusiness_Service@bcbst.com.

Note: Submission dates of claims filed electronically that are not accepted due to transmission errors are not accepted as proof of timely filing.

8. Code Edits

CMS developed the National Correct Coding Initiatives (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, Healthcare Common Procedure Coding System (HCPCS) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. Updated NCCI edits are published on The CMS website on a quarterly basis.

Code bundling edits are performed during the initial claim processing phase, when possible, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- The Outpatient Code Editor (OCE)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare and Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise
- BCPTN code bundling rules are also based on reimbursement policies such as, but not limited to, the following:
 - Bundled Services regardless of the Location of Service
 - Bundled Services when the Location of Service is the practitioner's office
 - Durable Medical Equipment (Purchase and Rentals)
 - Home Pulse Oximetry
 - Screening Test for Visual Acuity
 - Visual Function Screening
 - Quarterly Reimbursement Changes
- Medically Unlikely Edits (MUEs)

An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service. All HCPCS/CPT® codes do not have an MUE. BCBST reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records) to determine appropriate application of its code editing rules.

- Maximum Units of Service

Edits are also applied for maximum units of service derived from several sources: CMS, AMA CPT® (American Medical Association Current Procedural Terminology), knowledge of anatomy, the standards of medical practice, FDA (U.S. Food and Drug Administration) and other nationally recognized drug references and outlier claims data from provider billing patterns.

- Comprehensive and Component Code Pairs

Edits may be applied when all associated claims are processed in some situations. In those cases, the edit will be applied during the retrospective audit process when all associated claims are available for review. The Column One/Column Two Correct Coding Edits table includes code pairs that should not be reported together for a number of reasons. Code bundling rules reflect edits where a comprehensive and component code pair exists.

The column 1/column 2 correct coding edit table contains two types of code pair edits. In the "Comprehensive Code" edits table, the column 1 code generally represents the more significant procedure or service when reported with the column 2 code. When reported with the column 2 code, "column 1" generally represents the code with the greater work RVU of the two codes. The "Mutually Exclusive" edit table contains code pairs that Medicare believes should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If a provider submits two codes of a code pair edit for the same Medicare beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a NCCI/CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed. Below is an example of the coding edit table:

Column1/Column 2 Edits					
Column 1	Column 2	* - In existence prior to 1996	Effective Date	Deletion Date * =no data	Modifier 0=not allowed 1=allowed 9=not applicable
0001T	0002T		20030101	20040331	1
0001T	34800		20030101	20041231	1
0001T	34802		20030101	20041231	1
0001T	34804		20030101	20041231	1
0001T	36000		20021001	20041231	1
0001T	36410		20021001	20041231	1
0001T	90780		20021001	20041231	1
0002T	34800		20030101	20040331	1
0002T	34802		20030101	20040331	1

Note: The example above is an excerpt from the CMS CCI code table located at www.cms.gov

Although the Column 2 code is often a component of a more comprehensive Column 1 code, this relationship is not true for many edits. In the latter type of edit the code pair edit simply represents two codes that should not be reported together, unless an appropriate modifier is used.

Comprehensive (Column 1) code generally represents the major procedure or service when reported with another code.

Component (Column 2) code generally represents the lesser procedure or service. Reimbursement for a component code is considered included in the reimbursement for the comprehensive code when the service is billed by the same provider, for the same patient on the same date of service and is not made separately from the comprehensive code.

Code bundling can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code. Providers can access the most current code bundling rules for code pairs via <http://www.cms.gov>.

9. Sexually Transmitted Infections Testing

For professional providers submitting claims for sexually transmitted infection (STI) testing, there are single STI CPT® codes (87491, 87591, 87661) which are differentiated by the specific causative infectious agent. Separately, there is a comprehensive STI CPT® code (87801), which is for more than one organism tested.

Effective for claims with dates of service on or after October 1, 2025, BCBST will deny claims with two or more single STI testing CPT® codes performed by the same provider on the

same date of service and ask provider to refile with the more comprehensive STI CPT® test code.

This policy applies to services billed on a professional claim form – CMS-1500 or electronic equivalent.

10. Same Day Evaluation & Management (E&M) and Preventive Medicine Exam Payment Policy

BCBST allows separate reimbursement for professional providers submitting claims for routine or problem focused E&M services with a preventive medicine service (CPT® codes 99381-99387 or 99391-99397) during the same patient encounter using a modifier 25 on the E&M service code line of the claim.

Effective for claims with dates of service on or after January 1, 2026, BCBST will reimburse separately for these services as follows:

- Modifier 25 should be appended to the E&M service code
- Appropriate diagnosis codes must be included on the claim for the respective services

If this criteria is met, then the E&M service will be reimbursed at 50% of the appropriate fee schedule. The Preventive Medicine service will be reimbursed at 100%.

This policy applies to services billed on a professional claim form – CMS-1500 or electronic equivalent.

11. Discontinued and Reduced Services/Procedures (Modifiers 52, 53, 73,74)

In surgical or procedural services represented with a CPT code, there are situations where the intended procedure is not fully completed, and these are identified on provider claims with a modifier 52 or 53, and on facility claims requiring anesthesia, with a modifier 73 or 74.

Specifically, modifier 52 should be attached to codes when the surgeon completed the procedure but did not fulfill all the requirements, and modifier 53 should be used for procedures that are terminated by the surgeon, typically because of the patient's condition. Modifier 52 indicates reduced services, while modifier 53 indicates a discontinued procedure. If the surgeon discontinued the procedure without completing the treatment as planned, use modifier 53. If the service is complete, use modifier 52.

Modifier 73 should be appended to a procedure claim when the procedure is discontinued before planned anesthesia. Modifier 74 will apply when the procedure is discontinued after planned anesthesia. These modifiers apply only to procedures that require anesthesia. They are used to cancel an operation before or after anesthesia is provided. In scenarios where a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure, discontinued services modifiers do not apply.

Effective for claims with dates of service on or after January 1, 2026, BCBST will reimburse discontinued or reduced services for providers as follows:

- Reduced Services, identified with a modifier 52, at 50% of the appropriate fee schedule.

- Discontinued Services, identified with a modifier 53, at 25% of the appropriate fee schedule.
- Discontinued Services before planned anesthesia, identified with modifier 73, at 25% of the appropriate fee schedule.
- Discontinued Services after planned anesthesia, identified with modifier 74, at 50% of the appropriate fee schedule.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

12. Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

Note: Effective 4/1/16 dates of service and after, reimbursement for DME providers to include: DME, Medical supplies, Orthotic & Prosthetics, and Specialty DME providers will be locked at 2015 CMS (Medicare Region C DMEPOS Fee Schedule for Tennessee published as of January 1st). There will be NO Annual updates to the maximum allowable for existing codes since these schedules will be locked at 2015 CMS rates. Updates to these fee schedules for new codes are indicated below, as stated in provider's contract.

New codes added to the DMEPOS fee schedule on or after Jan. 1, 2016, will be locked at:

- If CMS establishes a non-competitive bid payment amount for a new code: the highest CMS rate for Tennessee will be added and locked based on the contract percentage and the first published Medicare fee.
- a. If CMS establishes a Competitive Bid Program (CBP) single payment amount for a new code: the new code will be added with the rate locked at 100% of the first published Medicare fee. **Durable Medical Equipment (DME) and Medical Supplies**

Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits or enables the beneficiary to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions and/or illnesses. DME is considered to be equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are items, although durable in nature, which may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes.

CMS defines customized Durable Medical Equipment (DME) as being items of DME which have been uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating Physician.

Source: <https://www.cms.gov>

Medical Supplies are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment that have been ordered by a qualified Practitioner in the treatment of a specific medical condition and that are: consumable, non-reusable, disposable, for a specific rather than incidental purpose and generally have no salvageable value.

All supplies dispensed for home use by the Practitioner's office should be billed with the most appropriate HCPCS supply code(s) (i.e., dressings, elastomeric devices, flushes, etc.) and the appropriate POS code to indicate the location of utilization.

Claim Form

Durable medical equipment and medical supplies must be billed on a Professional claim form.

Block 24b – Place of Service

The place of service (POS) should represent where the item is being used, not where it is 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.

Note: DME providers will need to use “99” place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store.

Block 24a – From and To Date(s) of Service

Enter the month, day and year for each procedure, service or supply.

The following items require the use of span dates (i.e., a span of time between the “from and to” dates of service). Failure to use span dates will result in incorrect payment for the following items:

- Enteral Feeding Supply kits
- Continuous passive motion device
- Enteral Formulae
- Food Thickener
- External Insulin Pump Supplies

EX: Code A4224 also includes all cannulas, needles, dressings and infusion supplies (excluding insulin reservoir A4225, (Supplies for external insulin infusion pump, syringe type cartridge, sterile each) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). Billing for more than one (1) unit of service per week is incorrect use of the code and will be denied accordingly.

Source: <http://www.cgsmedicare.com>.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the “From” field and the ending rental date of service in the “To” field of the CMS-1500/ ANSI-837P for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.

All DME monthly rentals must not be billed with a DOS span and must bill only one (1) unit per month.

Block 24d - Codes and Modifiers

Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. In some cases, more than one pricing modifier is required. Claims billed with an inappropriate code and modifier combination will be returned to the provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g., E1399) should only be used when a more specific CPT® or HCPCS code is not available or appropriate. Components of the primary equipment should be billed with the most specific CPT® or HCPCS code or the most specific Unlisted, Miscellaneous code.

- Durable medical equipment billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.

Pricing modifiers are always appended first in the modifier fields. These will always impact the reimbursement. Informational/descriptive modifiers are used in the subsequent modifier fields. These modifiers are informational or utilized for benefit management by Medicare but do not impact reimbursement amounts.

The following is a partial list of common pricing HCPCS modifiers reported with HCPCS durable medical equipment codes:

Modifier	Description
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with surgical dressing
KF	Item designated by FDA as class III device
KR	Rental item, billing for partial month
NU	New equipment
RR	Rental (use the RR modifier when DME is to be rented)
UE	Used durable medical equipment
KL	DMEPOS item delivered by mail
KE	Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment

Labor for DME repairs to Member-owned equipment is to be billed using the most appropriate 5-digit HCPCS code. A modifier will not be required with the labor codes.

Codes and modifiers must be billed in accordance with the following:

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C guidelines which include, but are not limited to the following:
 - DMEPOS Supplier Manual and Revisions
 - DME MAC Jurisdiction C Fee Schedule
 - Pricing, Data Analysis and Coding Contractor (PDAC*) Product Classification Lists
 - Pricing, Data Analysis and Coding Contractor (PDAC*) Coding Bulletins

*This document is located at https://www4.palmettogba.com/pdac_dmecs/.

Block 24g - Days or Units

For monthly rentals, one unit should be billed for each month the item is rented as the maximum allowable for the rental is for a whole month.

For partial month rentals, one unit should be billed for each month the item is rented. BCBST reserves the right to prorate the maximum allowable to reflect the partial month rental.

For rentals with DME codes and supply kits requiring span dates, one unit should be billed for each day the item is rented or supplied as the maximum allowable is for one day. For enterals, food thickener and external insulin supplies requiring span dates, the units are to be billed in accordance with the unit defined in the code description.

General Billing Guidelines

- The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services including mileage are not separately billable.
- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law.
- Remote therapeutic monitoring treatment/assessment services furnished personally/directly by a non-physician qualified health care professional, are considered professional services and are not billable by the DMEPOS/supplier provider.

Maintenance and/or service charges for durable medical equipment covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.

- Supplies and accessories related to DME must be billed in accordance with DME MAC for Jurisdiction C guidelines and be on the same claim form as the rented DME.
- There must be a valid detailed order on file prior to submitting claims for supplies.
- Regular submission of claims for supplies that exceed the usual utilization may prompt a request for medical records to support the need for additional supplies.
- Additional supplies must be requested by a Member or caregiver before being dispensed. Supplies are not to be automatically dispensed on a predetermined regular basis.
- Claim submission for reimbursement consideration should be done on a monthly basis. Only enough supplies to meet the member's need for one month should be dispensed at a time.
- The continued need for supplies and the amount on hand must be verified prior to dispensing additional supplies.

Codes without a published Medicare fee - BCBST reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.

- Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for leased DME will be based on the reimbursement provisions for rented DME.

Ventricular Assist Device (VAD) Supply or Accessory

Effective Dec. 1, 2017, supplemental information will no longer be required when filing medical CMS1500/ANSI-837P claims with HCPCS Codes Q0508 and Q0509 (Miscellaneous supply or accessory for use with an implanted ventricular assist device) unless specifically requested as indicated below.

The most appropriate codes to use for these dressing supplies are HCPCS codes Q0508 or Q0509. The prepackaged supplies typically contain various items including but not limited to gloves, gauze, tape, anchoring device, bouffant cap, local antiseptic (betadine/dyna dex/chloraprep), and facemask. If there is a specific code for an associated supply or accessory, that specific code should be billed for the item. When billing for a miscellaneous

supply or accessory for use with a VAD, (Q0508 or Q0509), the following documentation should be on file and available upon request:

- Physician's order for supply/accessory listing frequency and duration of its use
- Invoice for supply/accessory provided
- List of supply/accessory provided whether individually or in a kit
- Office/progress notes for the Member documenting the presence of a LVAD device

Q0508 or Q0509 will be reimbursed as 1 unit per month and shall include all supplies necessary to treat members' VAD dressing changes.

Aerosol Therapy

- Equipment used in conjunction with aerosol therapy must be billed by a durable medical equipment Provider.
- Supplies used in conjunction with aerosol therapy must be billed by a durable medical equipment provider or medical supplier.
- Inhalation medication used in conjunction with aerosol therapy must be billed through Member's pharmacy program.

Enteral Therapy

Equipment used with enteral therapy must be billed by a durable medical equipment provider.

Supply kits, pumps and formulae used with enteral therapy must be billed by a durable medical equipment provider or medical supplier. These items must be billed with the most appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be billed as follows:

Supply Kits – The appropriate “B” HCPCS code should be billed with span dates using one unit for each day a kit is used. These are disposable supply items, and no modifier is required to indicate a purchase. A span date indicates the time period services were provided; i.e., 01012021 to 01152021. Because of the use of span dates, a separate line item is not required for each day.

The codes for enteral feeding supplies include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the beneficiary for one day. These supply kit codes describe a daily supply fee rather than a specifically defined “kit”. Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged “kits” bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding.

Source: <http://www.cgsmedicare.com/>

Pump (if used) – Pumps are considered as monthly rentals. The “from” and “to” dates on the claim should indicate the month, day and year for the rental; i.e., 01012015 to 01012015. One unit should be used for each month the pump is rented.

Formulae – Span dates should be used to indicate the period formulae were provided. Formulae are billed with one unit for 100 calories. If formulae has not been assigned a specific HCPCS code by Pricing, Data Analysis and Coding Contractor (PDAC), bill formulae using B9998 with one unit for each 100 calories. BCPTN requires the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement.

Note: If different formulas which share the **same HCPCS code** are provided, only **a single line item of the code** should be billed. The units should indicate the total calories (i.e., 1 unit = 100 calories) of all formulas supplied with this same code during the same span date. The NDC and/or product name of one formula may be reported in the “Additional Information” section (See **Additional Information** section above). Block 19 – Reserved For Local Use, section of the CMS-1500 or its electronic equivalent, may be utilized if reporting of additional NDC/formula product information is required. Billing multiple lines of the same formula code for the same span date may result in delay of reimbursement.

Food Thickener - Span dates should be used to indicate the period thickener was provided. Food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned Pricing, Data Analysis and Coding Contractor (PDAC). Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box, or container. BCPTN requires the complete brand name, volume of container supplied, manufacturer's name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

Note: Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding.

DME Repairs, Adjustments, and Replacements

- If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the rental for the equipment and are not separately billable.
- Reimbursement for reasonable and necessary parts and labor to Member-owned equipment which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the modifier 1 field. Labor should be billed using the most appropriate HCPCS code. A modifier will not be required with the labor codes.
- Repairs to Member-owned durable medical equipment are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess.
- Billable parts and labor must be billed on the same claim form.
- Mileage is not separately reimbursed or billable.
- Temporary replacement for Member-owned equipment while being repaired billed a K0462 require a description and procedure code of the Member-owned equipment being repaired.
- Thirty (30) days is allowed for rental or loaner equipment when Member-owned equipment is being repaired.

Guidelines for Wheelchairs

- All accessories related to the purchase of a wheelchair base must be billed on the same claim form as the wheelchair base itself.

- If multiple accessories are provided using the miscellaneous code K0108, each should be billed on a separate claim line.
- Code E1028 is appropriate for swing away, removable, or retractable hardware (e.g., joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g., hardware for seat, back or tray).
- A separate claim line is required for each item billed with code E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.
- Bilateral accessories should be submitted with the right and left modifiers in the secondary modifier fields.

For information on items appropriately billed with code E1028, refer to DME Product Classification List located at [Palmetto GBA - DMECS](#).

b. Reimbursement Guidelines for Home Pulse Oximetry

Spot Home Pulse Oximetry

A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide adjunctive information for the clinician. It is no different than any other routine vital sign (e.g., blood pressure) obtained as part of a general patient assessment. Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check. When used as a spot oxygen saturation check, home pulse oximetry should not be billed separately from the rental of oxygen equipment or the home health visit.

Continuous Home Pulse Oximetry

Reimbursement for Medically Appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a Professional claim form for all BCBST business.

Note: Durable Medical Equipment Reimbursement Methodology applies to BCBST contracts only.

B. Health Insurance Form CMS-1500

1. Overview

The Form CMS-1500 version 02/12 is used by health care professionals and suppliers, and in some cases, for ambulance services. More instruction is available at the NUCC website for the www.nucc.org

All professional services should be filed on the CMS-1500 claim form or its electronic equivalent. These include:

- Professional Outpatient Services;
- Emergency Room Physician Fees must be filed with Location Code 23 (Emergency Room, Hospital)
- Clinic Visits (professional fees)

Professional claims need a taxonomy code to be submitted for the billing and rendering NPIs. It is extremely important that both the billing and rendering provider taxonomy codes match the

taxonomy codes on file for BCPTN. If you don't submit the appropriate taxonomy codes for BCPTN, your claims may be denied, or the reimbursement reduced.

A claim is a request for payment of BCPTN benefits for services furnished by a health care professional or supplier. Claims must be submitted within one year from the date of service and BCPTN members cannot be charged for completing or filing a claim. Offenders may be subject to penalty for violations.

The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) Web site, www.nucc.org. A sample copy of the CMS1500 (02/12) claim form and block descriptions are as follows:

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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <input type="checkbox"/> PICA													
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____				15. OTHER DATE MM DD YY QUAL. _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____		22. RESUBMISSION CODE ORIGINAL REF. NO. _____							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				23. PRIOR AUTHORIZATION NUMBER _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSONI Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. Rsvd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____				32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____				33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____					

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

2. General Instructions

A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

- Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- “Super bills,” statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.
- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
- The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
- Use standard fonts: do not intermix font styles on the same claim form.
- Do not use italics and script on the form.
- In completing all claim information COLOR OF INK should be as follows:
 1. Computer generated color of black
 2. Manual typewriter standard of Sinclair and Valentine J6983
- Use upper case (CAPITAL) letters for all alpha characters.
- Do not use dollar signs (\$), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.
- Extraneous data (handwritten or stamped) may not be printed on the form.
- Pin feed edges should be evenly removed prior to submission.
- We don’t accept split billing unless requested to reflect covered charges allocated for approved and denied dates of service. Split bills that haven’t been requested are subject to denial or recovery.
- All services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission.

Form Alignment

The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled “PICA”. These boxes should be considered Line 1, Columns 1, 2 and 3, and Line 1, Columns 77, 78 and 79. Form alignment can be verified by printing “X’s” in these boxes.

Entering All Dates

In Blocks 3, 9B, and 11A please include a space between each digit. The blank space should fall on the vertical lines provided on the form.

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY

MM=month (01-12)

1 blank space

DD=day (01-31)

1 blank space

CC=century (20, 21)

YY=year (00-99)

H3259_W14_P2_20260401

The blank space should fall on the vertical lines provided on the form. Do NOT exclude leading zeros in the date fields.

(Correct: January 1, 1924 = 01 01 24; Incorrect: 1124).

Note: New requirement for Block 24A. Omit spaces in Field 24A (date of service). By entering a continuous number, the date(s) will penetrate the dotted vertical lines used to separate month, day, and year. This is acceptable. Ignore the dotted vertical lines without changing font size.

For Block 24A

MMDDCCYY

MM=month (01-12)

DD=day (01-31)

CC=century (20, 21)

YY=year (00-99)

Physical Claim Form Specifications

While CMS-1500 claim forms can be ordered from the Government Printing Office, some providers may elect to deal with independent form vendors. All CMS-1500 claim forms must conform to the following print specifications:

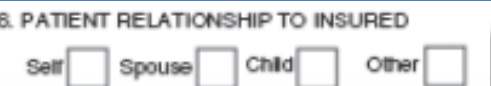


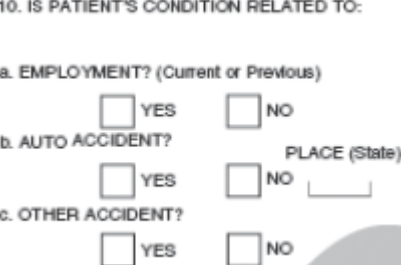

- PAPER
 - OCR bon -JCP25
 - 20 pound
 - 217 mm x 281mm (+ or -2mm)
 - Cut square, corners 90 degrees (+ or -.025)
- INK
 - Standard is Sinclair and Valentine J6983
 - Same ink front and back of form
 - Multi-part forms must have same ink on all copies
- MARGIN
 - Top to typewriter alignment bar is 34mm
 - Right to left margin is 9mm
- ASKEWITY
 - No greater than .15mm in 100mm



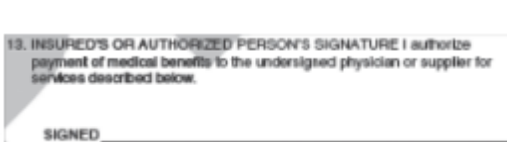

X and Y OFFSET for MARGINS must not vary by more than + or -0.010 inches from page to page (x= horizontal distance from left margin to print, y= vertical distance from top to print). NO MODIFICATIONS may be made to the CMS-1500 without the prior approval of the Centers for Medicare and Medicaid Services.

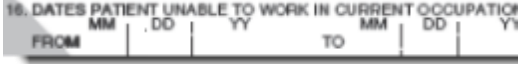



3. CMS 1500 Quick Reference Guide

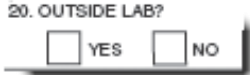

Below is a description of each block on the form for completing each area.

Block	Description	CMS 1500 Form Examples
1	Identify the applicable health insurance coverage (not required)	
1a	Enter the BCPTN member identification number (required) Example: Y12345678	
2	Enter the member's last name, first name and middle initial as appears on the BCPTN card (required)	
3	Enter the patient's birth date in the following format; MMDDCCYY and sex (required)	
4	Enter primary insurance either through the patient's or spouse's employment or any other source. If the insured and patient are the same enter the word SAME (situational)	
5	Enter the BCPTN patient's mailing address, city, zip and telephone number (required)	

Block	Description	CMS 1500 Form Examples
6	When item 4 is completed check appropriate box (conditional)	
7	Enter insured's address and telephone if the same as patient enter SAME (conditional)	
8	Check appropriate box for marital status, employed or student (not required)	
9	This field may be used in the future for supplemental insurance plans	
9a-d	Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary for a Medigap policy	(conditional)
10a-c	Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services (required if applicable)	
10d	<p>Claim Codes (Designated by NUCC)</p> <p>Not required dual eligible BCPTN member utilize one ID number</p>	

Block	Description	CMS 1500 Form Examples
11	<p>Provider/Supplier made good faith effort to determine who is the primary payer (required)</p> <p>(See the MSP section of this manual)</p>	
11a-c	<p>Additional information only if there is other insurance</p>	
11d	<p>Enter if the patient is or may be entitled to benefits under any other healthcare coverage program other than the</p>	
12	<p>Patient or authorized representative signature with MMDDYY date, unless signature is on file. If no signature is on file, leave blank or enter "No Signature on File"</p>	
13	<p>The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. IF there is no signature on file, leave blank or enter "No Signature on File"</p>	
14	<p>Date of current illness, injury or pregnancy (MMDDCCYY or MMDDYY). Chiropractic initiation of course of treatment (required)</p>	

Block	Description	CMS 1500 Form Examples
15	Leave blank. Not required.	
16	Date when patient is unable to work, if employed (situational)	
17	Enter the name of the referring/supervising or ordering physician if the service or item was ordered or referred by a physician (preferred but not required) along with the appropriate qualifier: <ul style="list-style-type: none"> • DN Referring Provider • DK Ordering Provider • DQ Supervising Provider 	
17a	Leave blank	
17b	Enter NPI of referring/ordering/supervising physician from item 17 when item 17 is completed (required)	
18	Enter date when a medical service is furnished as a result of, or subsequent to, a related hospitalization (MMDDYY or MMDDCCYY) (situational)	
19	Enter date patient was last seen and the NPI of his/her attending physician when a	

Block	Description	CMS 1500 Form Examples
20	<p>physician providing routine foot care submits claims</p> <p>Complete when billing for diagnostic tests subject to anti-markup payment limitation (situational)</p>	
21	<p>Enter patient’s diagnosis/condition. Code to the highest level of specificity for date of service (DOS) in priority order, version 02/12 accommodates ICD-10-CM (required)</p>	
22	<p>Resubmission Code</p> <p>This block is to be used when submitting a corrected claim</p> <p>“Resubmission” means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.</p> <ul style="list-style-type: none"> • A Resubmission Code should be filed in the first portion of Block 22. The valid values for this field are “7” Replacement of prior claim and “8” Void/Cancel of prior claim. These codes should be left-justified in the box so that they 	

Block	Description	CMS 1500 Form Examples
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will be processed correctly.

- The original claim number issued to the claim being corrected should be filed in the Original Ref. No. portion of Block 22.
- This block is not intended for use for original claim submissions.
- Failure to include the proper “Resubmission Code” and “Original Ref. No.” may result in a claim rejection or denial.






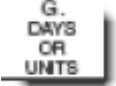


23 Enter Quality Improvement Organization (QIO) prior authorization number for procedures requiring QIO prior approval (situational)




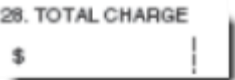

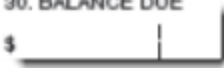
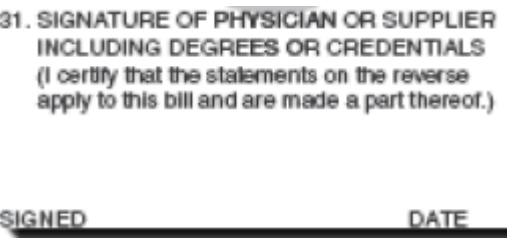



NOTE: For Ground and Air Ambulance services, pick up location zip code should be entered in this block. Block 32 can be used to document the drop off location’s zip.

24 Six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service (following will describe each item)

21. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE		C. DIAG		D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)		
From	To									MODIFIER
MM	DD	YY	MM	DD	YY	01	02	03	04	05
E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM Family Pt		I. ID. QUAL.		J. RENDERING PROVIDER IC

Block	Description	CMS 1500 Form Examples
24 a	Date for each procedure, service, or supply MMDDCCYY format (required)	
24 b	Enter appropriate place of service code(s) for each item used or service performed (required)	
24 c	Not required	
24 d	Enter procedures, services or supplies using HCPCS code(s). Modifiers if applicable (required)	
24 e	Enter diagnosis code reference number to relate the date of service and procedures performed to the primary diagnosis (required)	
24 f	Enter the charge for each listed service (required)	
24 g	Enter the number of days or units (required)	
24 h	Leave blank (not required)	
24 i	Enter the ID qualifier 1c (required)	
24 j	Rendering provider's NPI number (required)	

Block	Description	CMS 1500 Form Examples
25	Enter Federal Tax ID (Employer Identification Number or Social Security Number) (required)	
26	Enter patient's account number assigned by provider of service (required)	
27	Check block to indicate if supplier accepts assignment of Medicare benefits (required)	
28	Enter total charges for services (required)	
29	Enter total amount patient paid on covered services only if applicable	
30	Leave blank (not required)	
31	Enter signature of provider of service and date the form was signed (MMDDYY or MMDDCCYY) (required)	
32	Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office (required)	

Block	Description	CMS 1500 Form Examples
	Note: This block can be used to document the drop off location's zip.	
33	Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number (required)	
33 A	Enter the Billing provider's NPI	
33 B	Enter the two-digit qualifier identifying the non-NPI number followed by the ID number	

C. CMS 1450 Facility Claim Form

1. Overview

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Facility claims submitted to BCPTN must be filed on the CMS-1450 (UB-04) paper claim form or its electronic equivalent.

BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

The UB-04 contains a number of improvements and enhancements over the UB-92 paper claim form that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form is able to accommodate the reporting of the National Provider Identifier (NPI) Number. The NPI is a single provider identifier, replacing the different provider identifiers health care systems used for each health plan with which they do business. The NPI Identifier, which implements a requirement of Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by all HIPAA covered entities, which are health plans, healthcare clearinghouses, and healthcare providers.

A sample copy and field descriptions of the CMS-1450 claim form follow:

CMS 1450-UB04

1		2		3		4	
5		6		7		8	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	
101		102		103		104	
105		106		107		108	
109		110		111		112	
113		114		115		116	
117		118		119		120	
121		122		123		124	
125		126		127		128	
129		130		131		132	
133		134		135		136	
137		138		139		140	
141		142		143		144	
145		146		147		148	
149		150		151		152	
153		154		155		156	
157		158		159		160	
161		162		163		164	
165		166		167		168	
169		170		171		172	
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185		186		187		188	
189		190		191		192	
193		194		195		196	
197		198		199		200	
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205		206		207		208	
209		210		211		212	
213		214		215		216	
217		218		219		220	
221		222		223		224	
225		226		227		228	
229		230		231		232	
233		234		235		236	
237		238		239		240	
241		242		243		244	
245		246		247		248	
249		250		251		252	
253		254		255		256	
257		258		259		260	
261		262		263		264	
265		266		267		268	
269		270		271		272	
273		274		275		276	
277		278		279		280	
281		282		283		284	
285		286		287		288	
289		290		291		292	
293		294		295		296	
297		298		299		300	
301		302		303		304	
305		306		307		308	
309		310		311		312	
313		314		315		316	
317		318		319		320	
321		322		323		324	
325		326		327		328	
329		330		331		332	
333		334		335		336	
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361		362		363		364	
365		366		367		368	
369		370		371		372	
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2. General Instructions

The UB-04 claim form is a hard-copy facility/institutional claim used by providers/suppliers to submit charges for services. The description below includes specifications for each form locator (field) of the UB-04 claim form. Additional instruction and information can be reviewed at the [National Uniform Billing Committee Website](#).

Note: We don't accept split billing unless requested to reflect covered charges allocated for approved and denied dates of service. Split bills that haven't been requested are subject to denial or recovery. All services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission.

D. Institutional Claim Billing and Reimbursement Guidelines

The following guidelines are used in administering DRG reimbursement:

1. DRG Assignment

The DRG assignment will be based on the principal diagnosis, up to twenty-four (24) other secondary diagnoses, procedures, additional associated present on admission codes, as well as age, sex, and discharge status of patient. If CMS changes the DRG assignment criteria, BCPTN will remain on current grouper assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until such time that the parties mutually agree, the contracted DRGs will be utilized. In the event the parties cannot reach an agreement, the dispute shall be resolved by the Provider Dispute Resolution Procedure as described in this Manual. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

2. Inpatient Short Stay Payments

Inpatient stays for Observation will be subject to retroactive audit. Medical records that support the claim will be reviewed to determine if the payment is for services rendered. Where BCPTN has paid for services beyond those actually provided, a recovery will be processed in accordance to audit recovery procedures. The claims will be adjusted in agreement with the allowed amount for Observation Services provided in an outpatient setting. To facilitate a more accurate accounting of the service, Institutions are encouraged to authorize Observation Services and bill these stays appropriately in an outpatient setting when applicable.

Under all circumstances, BCPTN shall be the ultimate determiner of the DRG assignment. Hospitals that disagree with the DRG assignment, a request for review may be submitted.

3. Expired Patient Payments

If a member expires after admission, full DRG will be allowed. The patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

4. Transfer Payments

If a member is transferred to another facility for the same or similar condition, a discharge as defined under the DRG payment system has not occurred. Cases that have been transferred are considered normal admissions for the receiving Institution and payment to there will be made in accordance with Provider Agreement. The facility transferring the member is paid

based upon outlier per diems not to exceed the appropriate inlier payment. These claims are identified by the Discharge Status Codes filed on the claim as follows: 02, 05, 66, 70, or 82-85. The facility from which the member is ultimately discharged receives the full DRG payment rate. When billing for a transfer payment, the appropriate discharge status must be indicated on the CMS-1450 claim in Form Locator 17, or its electronic claims equivalent. BCPTN will authorize payment only if:

- The receiving facility initiated and followed the transfer review procedures of BCPTN; and the services were medically necessary.

5. Readmission Reimbursement

Submitting a corrected bill or combining the services from a readmission with those of the initial (index) admission will result in all services on the claim being disallowed. Also, billing with a "leave of absence" revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate without a Condition Code 44 appended, and services will be disallowed.

6. Readmission Quality Program

(i) 31-Day Same or Similar Cause Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Because of this, BlueCross has developed a readmissions program to more closely align with how CMS evaluates our Plan.

BlueCross will reimburse for a readmission within thirty-one (31) days from an index admission as follows:

- For purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 31-day window.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract are included in this program.
- Readmissions in the 31-day window should also have a modifiable cause leading to the readmission. Because readmissions are a multi-stakeholder concern, the modifiable cause doesn't have to only be for direct illness related complications but also issues that arose from the discharge plan. These include, but aren't limited to, the member not receiving new prescriptions, home health not showing up on time at the member's residence or lack of transportation to make outpatient appointments after discharge, etc.
- For readmissions on or after May 1, 2025, the facility reimbursement under this Same or Similar-Cause Readmission Quality program allows reimbursement for the index admission, but

not the readmission. The index admission will be paid at normal contracted rates.

- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing admission for active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.
- Readmissions occurring within the original 31-day window from the original index admission discharge will be bundled into the original admission if the above parameters are met. A new index readmission isn't set until a full 31 days have elapsed.

Note: *The Member cannot be held liable for payment of services received when not authorized.*

(ii) 48 Hour Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Additionally, Medicare specifically identifies short term readmissions as a likely deviation in quality of care in the original discharge plan or discharges occurring before the Member was stable for transition of care. Because of this, BlueCross has developed a readmissions program to more closely align with how CMS evaluates our Plan.

BlueCross will reimburse for a readmission within forty-eight (48) hours from an index admission as follows:

- For purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 48-hour window.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract, are included in this program.
- Because of the proximity to the index discharge, there is no modifiable cause component of this program.
- Also, because this readmission program has a contractual denial of the readmission, the Medical Necessity of the readmission is not evaluated.
- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.
- The provider may file an appeal by following the steps in the denial letter.

- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing admission for active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.

Note: The Member cannot be held liable for payment of services received when not authorized.

7. Left against Medical Advice

In the event that a member discharges himself or herself from the facility, against the advice of their doctor, payment will be made based upon outlier per diems not to exceed the appropriate inlier payment. Patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

8. Unbundling of Services

The BCPTN rates are calculated with the assumption that professional and/or technical components of hospital-based practitioners and Certified Registered Nurse Anesthetists (CRNAs) will be separately billed on a CMS-1500 claim form. Bills for hospital-based practitioners and CRNA services must be submitted on a CMS-1500.

9. Outpatient Services Treated as Inpatient Services

Pre-admission Diagnostic Services performed on an outpatient basis by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility), within three days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period. Other Pre-admission Non-Diagnostic Services that are related to the member's facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period. The term "day" refers to the calendar day(s) immediately preceding the date of admission or day following discharge. For example, if a member is admitted on Wednesday, services provided on Sunday, Monday and/or Tuesday are included in the inlier portion of the DRG payment, as opposed to 72 hours from the admission hour.

Exclusions: Ambulance Services, Chronic Maintenance Renal Dialysis Treatments, Home Health Services, Inpatient Services.

10. Policy for Present on Admission (POA) Indicators

This policy applies to claims billed on a CMS-1450/UB-04/ANSI-8371. Inpatient admissions to general acute care hospitals, requires the Present on Admission (POA) code on diagnoses (Form Locator 67) for discharges on or after Dec. 31, 2007, by using National Coding Standard guidelines.

This may impact reimbursement. POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by The Centers for Medicare & Medicaid Services (CMS) POA Indicator Options:

Present on Admission (POA) Indicator Options:

- Y = Diagnosis was present at time of inpatient admission.
- N = Diagnosis was not present at time of inpatient admission.
- U = Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- 1 = Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.

The Present on Admission Indicator Reporting requirement applies only to Acute Inpatient Prospective Payment System (IPPS) hospitals. Facilities (as indicated by CMS) that are exempted from the POA Indicator requirements will not be required to submit the POA Indicator Option "1".

When filing electronic ANSI 837 inpatient facility claims, providers should no longer enter Indicator Option "1" in the POA field when exempt from POA reporting. The POA field should be left blank for EDI format 5010 claims.

When filing paper CMS-1450 (UB04) inpatient facility claims, providers should enter a "1" in the POA field when exempt from POA reporting.

When any other POA Indicator Options apply, they should be reported in the POA field on both electronic and paper claims.

Claims will reject if:

- POA "1" is submitted on an electronic ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the Centers for Medicare & Medicaid (CMS) website at <http://www.cms.gov/HospitalAcqCond/>.

Emergency/Non-emergency

Emergency Room Services:

Emergency Room services (revenue code 0450) do not require an authorization. Reimbursement will be based upon the current fee schedule. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

Emergency Room Services filed with Observation:

Observation room (revenue code 0762) is considered part of the emergency room charge and is not reimbursed separately.

Emergency Room Services filed with Outpatient Surgery:

Emergency Room services (revenue code 0450) filed with Outpatient Surgery will be reimbursed in addition to the outpatient surgical reimbursement. Ancillary services are considered all-inclusive in the Outpatient Surgical Fee (OSF) reimbursement.

Emergency Room Services filed with Observation and Outpatient Surgery:

Emergency Room services (revenue code 0450) and Observation services filed with Outpatient Surgery services are considered all-inclusive in the Outpatient Surgery reimbursement and are not reimbursed separately. Ancillary services are considered all-inclusive in the OSF reimbursement.

Emergency Room Services filed on an Inpatient CMS-1450 claim form (Inpatient setting):

Emergency Room services filed on a CMS-1450 claim are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

Observation filed with Outpatient Surgery:

Observation charges may not be billed until six (6) hours after surgery. Recovery times up to six (6) hours are included in the outpatient surgery all-inclusive rates.

Observation filed on an Inpatient claim (inpatient setting):

Observation services filed on a CMS-1450 claim form are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

*Incidental services include but are not limited to those services billed under Revenue Codes:

- 0250 – 0259 (Pharmacy)
- 0270 – 0279 (Surgical Supplies)
- 0290 – 0299 (DME)
- 0370 – 0379 (Anesthesia)

11. Therapy and Rehab Services

Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF)

Type of Bill	Description
074X	Outpatient Rehabilitation Facility
075X	Comprehensive Outpatient Rehabilitation Facility

Revenue Code	Modifiers	Description
0420	GP	Physical Therapy

0430	GO	Occupational Therapy
0440	GN	Speech Therapy

Facilities are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFS are required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Freestanding Inpatient/Outpatient Rehabilitation Facilities and Skilled Nursing Facilities

Outpatient Rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

Type of Bill	Description
013X	Freestanding Inpatient Rehab Facilities-Outpatient Therapy Services
022X 023X	Skilled Nursing Facilities-Outpatient Therapy Services
074X	Outpatient Rehabilitation Facility
075X	Comprehensive Outpatient Rehabilitation Facility

The appropriate revenue codes are required to identify specific accommodation and/or ancillary charges. The numeric revenue code must be entered on the adjacent line in FL 42 to explain each charge in FL 47.

For additional information visit The Centers for Medicare & Medicaid Services (CMS) Website at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

12. National Drug Code (NDC) Billing

BlueCare Tennessee Provider Administration Manual National Drug Code (NDC) Claim Filing (Previously Provider-Administered Drug Claims)

Beginning January 1, 2007, the Deficit Reduction Act (DRA) of 2005 required states to collect rebates on provider-administered drugs. Effective with dates of service June 1, 2007, and forward, providers must include the National Drug Code (NDC) of the drug(s) administered, along with the correct quantity and unit, for all provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format with some exceptions indicated below. Home Infusion Therapy providers should continue submitting claims using the same codes in place today. All other providers should submit claims with the NDC information for "J" codes only.

Exceptions to NDC Requirement for Provider-Administered Medical and Facility Drug Claims:

- Inpatient administered drugs
- Vaccines

Note: Effective with date of service 4/01/08 and after, NDC requirements must also be fulfilled by facilities filing Outpatient UB claims on a CMS-1450 claim form or submitted electronically in

the ANSI-837 Institutional version format with the same exceptions listed above. NDC information is not required on Inpatient UB claims. When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/ CPT® code. Any missing element may result in the claim being returned unprocessed.

National Drug Code (NDC) Electronic Billing Requirements

When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/CPT® code. Any missing element will result in the claim being returned unprocessed.

In Loop 2410:

- **LIN02** must equal “N4” and **LIN03** must contain an 11 digit NDC number.

Example: LIN**N4*01234567891~

- **CTP04** must contain a numeric value, which quantifies the number of units, grams or milliliters administered. Decimal points are allowed in the event they are needed.
- **CTP05-1** must contain one of the NDC Quantity Qualifiers (**F2-International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-Unit**)

Example: CTP***2*UN~

Not Otherwise Classified (NOC) Drug Code Billing

When billing NOC J-codes in the ANSI 837 format you are required to provide a description of the drug in the 2400 Loop, SV101-7 (Professional), SV202-7 (Institutional).

Example: SV1/2*HC: J3490::::FOLIC ACID 5MG*5.62*UN*1***3~

In order for BCPTN to correctly reimburse NOC J-codes, providers must indicate the following in the electronic narrative: the name of the drug, total dosage (plus strength of dosage, if appropriate) and method of administration.

ANSI 837 Loop	Field Description	837P Segment	837I Segment
2400	Drug Name description information	SV101-7	SV202-7
2400	Drug Ingredient Billed Amount	SV102	SV203
2400	HCPCS Unit of Measure	SV103	SV204
2400	HCPCS Quantity	SV104	SV205
2410	NDC Qualifier of N4	LIN02	LIN02
2410	NDC code (11 digits)	LIN03	LIN03
2410	NDC Quantity	CTP04	CTP04
2410	NDC Unit of Measure (F2, GR, ME, ML, UN)	CTP05-1	CTP05-1

Paper Claim Submission -Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

In the shaded portion of Block 24 on the CMS-1500 (02/12) claim form:

- The first two positions must be “N4” and the next eleven positions must be the NDC code comprised of eleven numeric digits.
- The next position must be a space.
- The next two positions must be one of the NDC Quantity Qualifiers identified in the element table above.
- The next few positions must be a numeric value, which quantifies the number of units, grams, milligrams or milliliters administered. No specific number of digits is required; however, the number submitted may not exceed 15 digits. If entering a whole number, do not use a decimal. Decimal points are allowed in the event they are needed. Do not use commas.

For example, when specifying 2 micrograms, use the “ME” qualifier and add “0.002” as the quantity.

When entering supplemental information for NDC, add in the following order qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity.

The next three positions must be spaces.

The next two positions must be “ZZ” and the next few positions must be drug name.

Example: N450242006101 ME1.25 ZZAvastin

13. Dialysis Freestanding Facility

Clinic Claim Reimbursement for Completed CMS-2728-U3 Form

Effective January 1, 2023, initial dialysis clinic claims filed with Type of Bill 072X will require the submission of a completed CMS-2728-U3 form. The online fillable form is located on the CMS website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf>. Reimbursement will not be considered for dialysis clinic claims if a completed CMS-2728-U3 form is not on file with BlueCross BlueShield of Tennessee. The initial and subsequent claims will be denied requesting that the provider submit the completed form. Further information regarding ESRD (End Stage Renal Disease) may be found in section XIV (Risk Adjustment). Providers may submit the applicable CMS-2728-U3 form by fax to (423) 591- 9465, or by mail to BlueCross BlueShield of Tennessee, Attn: Revenue Reconciliation, 1 Cameron Hill Cr, Ste 0039, Chattanooga, TN 37402-0002

Dialysis Billing and Reimbursement Guidelines

- **Treatment Rate** – The base composite rate is adjusted by the treatment multiplier to arrive at the Treatment Rate BCPTN will allow for ESRD-related services. The adjusted Treatment Rate is considered to be an all-inclusive charge for services, teaching, supplies, lab and drugs. BCPTN allows the lesser of total covered charges or the treatment rates negotiated in the contract.

The Treatment Rate should only be billed to BCPTN when an actual dialysis treatment has been performed. Reimbursement for these services is an all-inclusive rate.

BCPTN will not reimburse for services billed in addition to the Treatment Rate as indicated in following chart. Any “other” services billed without a treatment RC as “stand alone” will deny as “Not paid in addition to primary service”. The relevant CPT® or HCPCS code is required in FL 44 in conjunction with appropriate RC in FL 42 for proper reimbursement. Claims submitted

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without required coding will be returned to the provider or denied per billing guidelines. Codes not specifically listed in the contract are not allowed and may not be billed to a BCPTN Member.

Form locators related to the composite rate should be completed on the Institutional claim form as described in the following table. Use the Institutional format when submitting electronic claims.

Revenue Code FL 42	CPT® Code / Required FL 44	Unit / Frequency FL 46	Treatment Rate FL 47
0821	90989	Per Visit	Treatment Rate
0821	90993	Per Visit	Treatment Rate
0821	90999	Per Visit	Treatment Rate
0831	90999	Per Visit	Treatment Rate
0841	90945	Per Visit	Treatment Rate
0841	90993	Per Visit	Treatment Rate
0851	90945	Per Visit	Treatment Rate
0851	90993	Per Visit	Treatment Rate
0881	90999	Per Visit	Treatment Rate

Condition Code Descriptions	Condition Code	Informational Only/ Does not affect reimbursement FL(s) 18-28
Home – Self-administered anemia management drug	70	Required
Full-Care in Unit	71	Required
Self-Care in Unit	72	Required
Self-Care in Training	73	Required
Home	74	Required
Home - 100% reimbursement	75	Required
Back-up In-Facility Dialysis	76	Required

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made.
- **Non-Reimbursable Revenue Codes (RCs)** – Unless specifically indicated in the contract, BCPTN will not reimburse for services billed in addition to the composite rate. In order to administer the contract, BCBST does not utilize the general RCs. Detail RCs and CPT® or HCPCS codes are required.

14. Home Health Services

All Home Health services require prior authorization; this includes the initial evaluation and treatment in order to prevent delay in patient care, we will administratively approve a set amount of initial visits with proper notification. Notification can be submitted with a diagnosis and the Physician order or home health referral prior to services being rendered. All Home Health services for BCPTN should be billed on the CMS-1450 claim form using CMS-1450 Type of Bill 032X. When submitting ANSI-837 electronic claims, the Institutional format must be used. HCPCS codes are required for all outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.

Note: Please use the appropriate therapy evaluation revenue code for services related to an evaluation.

Note: These coding changes do not affect current reimbursement.

Type of Service	Description	Revenue Code	Procedure Code
Home Health Agency Visits	Home Health Physical Therapy	0421	G0151 G0157 G0159
	Home Health Physical Therapy Evaluation	0424	G0151 G0157 G0159
	Home Health Occupational Therapy	0431	G0152 G0158 G0160
	Home health Occupational Therapy Evaluation	0434	G0152 G0158 G0160
	Home Health Speech Therapy	0441	G0153 G0161
	Home Health Speech Therapy Evaluation	0444	G0153 G0161

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Type of Service	Description	Revenue Code	Procedure Code
	Home health Skilled Nursing (RN or LPN)	0551	G0493 G0494 G0495 G0496 G0299 G0300
	Home Health Medical Social Services	0561	G0155
	Home Health Aide	0571	G0156
Home Health Extended Visits	Skilled Nursing Hour (RN)	0552	S9123
	Skilled Nursing Hour (LPN)	0552	S9124
	Home Health Aide Hour	0572	S9122
Private Duty	Private Duty Nursing	0589	T1000

Home Health services not billed with the indicated revenue codes and/or procedure codes may be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated. (This includes drug codes for the drugs provided with Home Infusion Therapy (HIT) per diem.)

Extended visits and Private Duty Nursing (Medicaid Benefit) are covered benefits for BlueCare Plus Choices members. Billing guidelines are as follows:

Extended visits are to be billed in whole hour increments. Fractional hours should be rounded to the nearest whole hour (e.g., 1 hour 15 minutes should be routed to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 45 minutes should be rounded to 2 units.)

The billing week is defined as Monday through Sunday. A separate claim is required for each billing week. Each service requires a separate claim line item for each date of service in the billing week. Submission of more than one claim per week will result in denial of the second and subsequent claims for that billing week.

The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 027X:

A4321	A4354	A4372	A4389	A4407	A4423	A4455	A5057	A5114	A7506	T4523	T4541
A4326	A4355	A4373	A4390	A4408	A4424	A4456	A5061	A5120	A7507	T4524	T4542
A4328	A4356	A4375	A4391	A4409	A4425	A4459	A5062	A5121	A7508	T4525	T4543
A4330	A4357	A4376	A4392	A4410	A4426	A4461	A5063	A5122	A7509	T4526	T4544
A4331	A4358	A4377	A4393	A4411	A4427	A4463	A5071	A5126	A7520	T4527	T4530

A4212	A4333	A4360	A4378	A4394	A4412	A4428	A4481	A5072	A5131	A7521	T4531
A4248	A4334	A4361	A4379	A4395	A4413	A4429	A4623	A5073	A6531	A7522	T4532
A4310	A4338	A4362	A4380	A4396	A4414	A4430	A4625	A5081	A6532	A7523	T4533
A4311	A4340	A4363	A4381	A9272	A4415	A4431	A4626	A5082	A7045	A7524	
A4312	A4344	A4364	A4382	A4398	A4416	A4432	A5051	A5083	A7047	A7526	T4534
A4313	A4346	A4366	A4383	A4399	A4417	A4433	A5052	A5093	A7501	A7527	T4535
A4314	A4349	A4367	A4384	A4400	A4418	A4434	A5053	A5102	A7502	T4521	T4537
A4315	A4351	A4368	A4385	A4404	A4419	A4435	A5054	A5105	A7503	T4522	T4540
A4316	A4352	A4369	A4387	A4405	A4420	A4436	A5055	A5112	A7504	T4528	
A4320	A4353	A4371	A4388	A4406	A4422	A4437	A5056	A5113	A7505	T4529	

The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

A6010	A6205	A6221	A6237	A6252	A6407	A6451
A6011	A6206	A6222	A6238	A6253	A6410	A6452
A6021	A6207	A6223	A6239	A6254	A6412	A6453
A6022	A6208	A6224	A6240	A6255	A6441	A6454
A6023	A6209	A6228	A6241	A6256	A6442	A6455
A6024	A6210	A6229	A6242	A6258	A6443	A6456
A6154	A6211	A6230	A6243	A6259	A6444	A6457
A6196	A6212	A6231	A6244	A6261	A6445	A6545
A6197	A6213	A6232	A6245	A6262	A6446	A7040
A6198	A6214	A6233	A6246	A6266	A6447	A7041
A6199	A6215	A6234	A6247	A6402	A6448	A7048
A6203	A6219	A6235	A6248	A6403	A6449	A6257
A6204	A6220	A6236	A6251	A6404	A6450	

Supplies on the Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) manual. Supplies not billed with the indicated Revenue Codes and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit is the responsibility of the Home Health Agency.

Prior authorization will be required for any non-routine supplies used in conjunction with skilled nurse care rendered either in the patient's home or in a facility. Charges for non-routine supplies will not be reimbursed if they are not included and reviewed within the authorization. Supplies not used in conjunction with a visit is not billable by the Home Health Agency provider. Charges for routine supplies not billed with associated services may be subject to review prior

to claim payment. Third Party reimbursement will only be allowed when there is absence of an associated skilled nursing care within the patient’s home or in a skilled nursing facility.

The only supplies that may be billed in addition to the above services are those indicated on the following Home Health Agency Non-Routine Supply List and must be authorized with the requested service.

E. General Billing and Reimbursement Information

When billing for services rendered to BCPTN members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional and CMS-1450 facility health insurance claim forms. Medical /clinical codes including modifiers should be reported in accordance with the governing coding organization. Please refer to your BCPTN contract for reimbursement specifics.

Note: General Provisions Eligible services not priced by the Centers for Medicare & Medicaid Services (CMS) will be based on a reasonable allowable fee as determined by BCPTN.

BCPTN reserves the right to request documents submitted to or issued by the Medicare Fiscal Intermediary or Carrier that are necessary to determine the appropriate fee under Medicare-based reimbursement methodology.

Should payments to managed care organizations participating in federal health care programs, such as BlueCross BlueShield of Tennessee or the applicable payor, be adjusted other than through the payment methodology for the applicable federal health care program, BlueCross BlueShield of Tennessee or the applicable payor may implement the same or a similar adjustment to payment rates and/or payments for Covered Services.

Providers have a right to appeal reimbursement under BCPTN. If a provider has information that Original Medicare would pay more for a service, documentation (e.g. copy of a remittance advice or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to BlueCross BlueShield of Tennessee, Attn: BCPTN, 1 Cameron Hill Circle, Ste 0002, Chattanooga, TN 37402-0005 for review, verification, and payment adjustment if appropriate. Please complete and attach a Provider Reconsideration form or Provider Appeal form, whichever is applicable, with your submission. (See section XV. Provider Appeals Process in this section for submission instructions.)

Details regarding Medicare reimbursement methodologies can be found on the CMS website, www.cms.gov. Links to the CMS website for specific provider types are located in the following grid. In the event CMS changes one or more of the links, refer to CMS website, www.cms.gov. If there is a conflict between the following information and information published by CMS, the information published by CMS will prevail.

Provider Type	CMS Link for Detailed Information
Ambulance Services	http://www.cms.gov/AmbulanceFeeSchedule/
Ambulatory Surgical Center (ASC)	http://www.cms.gov/HospitalOutpatientPPS
Clinical Laboratory	http://www.cms.gov/ClinicalLabFeeSched/

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	http://www.cms.gov/DMEPOSFeeSched/
End Stage Renal Disease (ESRD) Center	http://www.cms.gov/center/esrd.asp
Federally Qualified Health Centers (FQHC)	http://www.cms.gov/center/fqhc.asp
Home Health	http://www.cms.gov/HomeHealthPPS/
Hospice	https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice
Acute Inpatient Service	http://www.cms.gov/AcuteInpatientPPS/
Critical Access Hospitals	http://www.cms.gov/center/cah.asp
Hospital - Outpatient Services	http://www.cms.gov/HospitalOutpatientPPS/
Inpatient Rehabilitation Facility	http://www.cms.gov/InpatientRehabFacPPS/
Hospitals	http://www.cms.gov/center/hospital.asp
Inpatient Psychiatric Facility (IPF)	http://www.cms.gov/InpatientPsychFacilPPS/
Long-Term Care Hospital	http://www.cms.gov/LongTermCareHospitalPPS
Skilled Nursing Facilities	http://www.cms.gov/SNFPPS/
Part B Drugs	https://www.cms.gov/medicare/payment/fee-for-service-providers/part-b-drugs/average-drug-sales-price https://www.cms.gov/medicare/payment/fee-for-service-providers/competitive-acquisition
Physicians and Other Healthcare Professionals	http://www.cms.gov/center/physician.asp
Anesthesia	Anesthesiologists Center CMS
Health Professional Shortage Area (HPSA)	http://www.cms.gov/HPSAPSAPhysicianBonuses/
Rural Health	http://www.cms.gov/center/rural.asp

NOTE: BCPTN uses the following hierarchy for coding, billing, and reimbursement of claims.

1. Provider's contract
2. BCBST policies and procedures
3. CMS guidelines
4. Coding guidelines from CPT
5. Coding guidelines from coding organizations

Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the Member's healthcare benefits plan that permits the BCPTN plan to conditionally pay the provider when a third party causes the Member's condition. The plan follows Medicare policy where by law, 42 U.S.C. Section 1395y(b)(2) and Section 1862(b)(2)(A)/Section and Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Pursuant to 42 U.S.C. Section 1395y(b)(2)(B)(ii)/Section, Section 1862(b)(2)(B)(ii) of the Act and 42 C.F.R. 411.24(e) & (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, Physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the plan sponsor may recover in the same manner as CMS.

Similar to Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the provider may bill the plan as the primary payer. If the item or service is reimbursable under BCPTN and Medicare rules, the plan may pay conditionally on a case-by-case basis and will be subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. In situations such as this, the Member may choose to hire an attorney to help them recover damages.

BCBST Laboratory Testing Code Reimbursement Policy

This policy applies to reimbursement for BCBST Laboratory Testing Services as indicated below and billed on a professional or institutional claim form for all lines of business.

This policy outlines that certain diagnostic laboratory code testing procedures will be reimbursed based on BCBST Laboratory Testing Code Reimbursement policy editing criteria. The allowable for each test is subject to the provider's contracted reimbursement methodology. Please refer to these policies located under the Code Edit section of the BCBST website at BCBST.com.

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XIII. Remittance Advice

BCPTN issues notices called Remittance Advices (RA) to communicate claims processing decisions such as payments and adjustments. The RA provides justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes on the RA identify any additional action you may need to take; for example, an RA code may indicate you may need to resubmit the claim with corrected information.

The RA provides detailed payment information about a health care claim(s) and describes the payment; it also features valid codes and specific values that make up the claim payment.

Once you receive the RA you may:

- Post the decision and payment information automatically when a compatible provider accounts receivable software application is being used
- Identify reasons for any adjustments, denials or payment reductions
- Note when the Electronic Funds Transfer (EFT) payment issued with the RA is scheduled for deposit

The Remittance Advice displays the following columns.

Patient Information	
Last Name	This field displays the last name of the member.
First Name	This field displays the first name of the member.
Patient Account	This field displays the Medical Record Number (MRN) or Patient Account that was submitted on the claim.
Member ID	BCPTN assigned member identification.

Claim Information	
Claim Number	This field display the Claim Number assigned to the claim at the time it is received by BCPTN.
Recv'd DT	This field indicates the date BCPTN received the claim for processing.
Serv Prov	National Provider Identification Number
Date of Service From/Thru	This field indicates the start date of services and the last date of services on the processed claim.
Procedure/Modifier	This field indicates the HCPC or CPT code including any modifier appended by the provider of service(s).
Total Charges	This field indicates the total charges submitted by the provider.

Payment Information	
Patient Non-Covered	This field indicates the number of non-covered days or visits that are submitted by the provider when it is know that the days or visits are not covered by Medicare. Providers do not anticipate payment on non-covered days or visits.
Note	Remark Code
Contract Write Off	Provider Write off Amount
Note	Remark Code
Patient DED/COPAY	This field indicates the deductible and co-pay for covered services. The deductible/co-pay should not be billed to the member. This amount will automatically crossover to the member's assigned TennCare MCO for processing of member cost sharing.
Patient COINS	This field indicates the coinsurance for covered services. This amount should not be billed to the member. This amount will automatically crossover to the member's assigned TennCare MCO for processing of member cost sharing.
Other Insurance	This field indicates if other insurance or coverage applicable.
Claim Paid	This field indicates the amount paid by BCPTN including the sequestration amount.
Interest Paid	This field indicates if any interest has been applied to the amount paid.
Paid	This field indicates the total amount paid minus the sequestration amount.
Patient Owes	This \$0 cost sharing program unless for a non-covered service.

Included is an example of the BCPTN Remittance Advice



PROFESSIONAL
REMITTANCE ADVICE

LINE OF BUSINESS	MV01
REMIT/CHECK DATE	07/24/2013
INTERNAL PROVIDER NUMBER	
NPI NUMBER	
TAX IDENTIFICATION NUMBER	
CHECK NUMBER	
REMITTANCE NUMBER	
PAGE NUMBER	1 OF 6

PATIENT INFORMATION		CLAIM INFORMATION				PAYMENT INFORMATION							
LAST NAME	FIRST NAME	CLAIM NUMBER	DATE OF SERVICE	PROCEDURE / MODIFIER	TOTAL CHARGES	PATIENT NON-COVERED	CONTRACT	WRITE OFF	PATIENT DED/COINS	PATIENT COINS	OTHER INSURANCE/MEDICARE	CLAIM PAID INTEREST PAID	PATIENT OWES
PATIENT ACCOUNT #	MEMBER ID	REC'D BY / SERV PROV	FROM/THRU										
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013	A425BKSL	38.00	.00	21.00	.00	3.33	.00	.00	13.47	
	MEMBER ID	01/06/2013	0630-063013	A423BKNS	5.00	3.50	PSB		.00	.00	.00	.90	
			0630-063013	KL									
			0630-063013	A425BKNS	300.00	.00	300.00	E30	.00	.00	.00	.00	
			0630-063013	KL									
			0630-063013	A425BKSL	28.00	.00	18.15	B65	.00	1.97	.00	7.88	
			0630-063013	A425BKSL	84.00	.00	64.00	E30	.00	.00	.00	.00	
			0630-063013	E0607NKS	200.00	.00	127.66	B65	.00	14.47	.00	57.87	
				CLAIM TOTAL	635.00	3.50	532.58		.00	20.44	.00	78.51	3.60
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013	A425BKSL	28.00	.00	18.15	B65	.00	1.97	.00	7.88	
	MEMBER ID	01/06/2013	0630-063013	A425BKSL	32.00	.00	20.75	B65	.00	2.25	.00	9.00	
			0630-063013	A425BKNS	150.00	.00	150.00	E30	.00	.00	.00	.00	
				CLAIM TOTAL	210.00	.00	189.24		.00	4.22	.00	16.54	.00
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013	A423BKNS	5.00	3.50	PSB		.00	.00	.00	.90	
	MEMBER ID	01/06/2013	0630-063013	KL									
			0630-063013	A425BKSL	38.00	.00	21.16	B65	.00	3.33	.00	13.47	
			0630-063013	A425BKSL	28.00	.00	18.15	B65	.00	1.97	.00	7.88	
			0630-063013	A425BKNS	150.00	.00	150.00	PSB	.00	13.79	.00	55.15	
				CLAIM TOTAL	221.00	84.56	40.86		.00	19.73	.00	75.85	84.56
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013	A425BKSL	28.00	.00	18.15	B65	.00	1.97	.00	7.88	
	MEMBER ID	01/06/2013	0630-063013	A425BKNS	450.00	.00	450.00	E30	.00	.00	.00	.00	
			0630-063013	KL									
			0630-063013	A424KNS	60.00	.00	60.00	B65	.00	.00	.00	.00	
			0630-063013	A425BKSL	95.00	.00	95.00	E30	.00	.00	.00	.00	
			0630-063013	E0607NKS	200.00	.00	127.66	B65	.00	14.47	.00	57.87	
				CLAIM TOTAL	834.00	.00	753.13		.00	16.44	.00	64.43	.00
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013	A423BKNS	5.00	.00	3.50	B65	.00	.00	.00	.90	
	MEMBER ID	01/06/2013	0630-063013	A425BKNS	38.00	.00	21.16	B65	.00	3.33	.00	13.47	

PLEASE RETAIN FOR YOUR RECORDS

The Patient Deductible Copy of Coinsurance amounts should not be billed to the member. BlueCare Plus will forward these claims to the Bureau of TennCare for the processing of member cost sharing.

The patient deductible, copay and coinsurance amounts should not be billed to the member. BCPTN forwards these claims to the member's assigned TennCare MCO for processing of member cost sharing.

To discuss issues specific to your organization, please contact eBusiness Technical Support at (423) 535-5717, or (800) 924-7141, Monday – Thursday 8 a.m. to 5:15 p.m. (ET) or Friday 9 a.m. to 5:15 p.m. (ET). More information is also available at the following link:

<http://www.bcbst.com/providers/ecomm/>,

or you can contact us via email at eBusiness_Service@bcbst.com.

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data or revalidating enrollment, must use Electronic Funds Transfer (EFT) to receive payments. For EFT enrollment, information is available on the CAQH Solutions website at

<https://solutions.caqh.org>.

XIV. Risk Adjustment

Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage (MA) plans, such as BCPTN, for the health status and demographic characteristics of their enrollees.

CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-10-CM codes) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD-10 codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.

CMS looks to providers to code identified conditions accurately using ICD-10-CM coding guidelines with supporting documentation in their medical record. The physician's role in risk adjustment includes:

- Accurately reporting ICD-10-CM diagnosis codes to the **highest level of specificity** (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Notifying the Medicare Advantage plan of any erroneous data submitted and following the appropriate procedures to correct erroneous data (see Section VI. Billing and Reimbursement in this Manual for instructions on submitting a Corrected Bill).
- Submitting claims data in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).

Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. The CMS-HCC model relies on ICD-10-CM coding specificity.

1. Risk Adjustment Data Validation (RADV) Audits conducted by CMS

Annually, CMS selects (both random and targeted) Medicare Advantage (MA) Organizations for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by Medicare Advantage organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

2. Risk Adjustment Impact for Physicians and Members

It is important to keep in mind that the risk adjustment process also benefits the provider and the patient. Increased coding accuracy helps BlueCross BlueShield of Tennessee identify patients who may benefit from disease and medical management programs. More accurate health status information assists in matching health care needs with the appropriate level of care. Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-10-CM codes including,

- Secondary diagnoses, to the highest level of specificity

- Maintaining accurate and complete medical records (ICD-10-CM codes must be submitted with proper documentation)
- Reporting claims and encounter data in a timely manner

With provider assistance in providing accurate and timely coding for risk adjustment, unnecessary and costly administrative revisions can be avoided, and provide patients and BCBST's members with superior customer service.

3. Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:

Federal regulations require Medicare and its agents (BCBST) to review and validate medical records in order to avoid underpayments or overpayments. It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-10-CM code of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed.

Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses are reported.

Medical Record Documentation

- Documentation should be clear, concise, consistent, complete and legible.
- Documentation of coexisting conditions at least annually.
- Use standard abbreviations.
- Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-10-CM code on the date of service, and are signed and dated by the physician or physician extender).
- Identify patient and date on each page of the record.
- Authenticate the record with signature and credentials.

Progress Note Requirements:

- Progress notes must contain patient name and DOS on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the provider must sign each page of the progress note.
- Progress notes should follow the standard S.O.A.P. format.

Provider Signature Requirements on Progress Note:

- All progress notes must be signed by the provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the provider.
- Provider signature must be legible, i.e., "John Smith Doe, M.D." or "JSD, MD". If a provider's signature is illegible, a signature log must be completed.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: "Electronically signed", "Authenticated by", "Signed by", "Validated by", "Approved by", or "Sealed by". The signed EMR record must be closed to all changes.
- Sign off on medical records should be completed timely.

Diagnosis Documentation Requirements on Progress Note:

- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a “problem list”, which is not acceptable for risk adjustment submission.
- Use the words “history of” cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using “history of” for conditions the member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the member has diabetes in his history, it is still a current condition. Each progress note must be able to “**stand alone**”. Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

4. Releasing Medical Records

BCPTN has the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnosis for risk adjustment data submission to CMS. Providers may receive requests from the Risk Adjustment Department for medical records with specific dates of service for review. Confidentiality and General Consent

5. Confidentiality of patient information is important to BlueCross BlueShield of Tennessee.

Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file.

6. Risk Adjustment Data

Providers are encouraged to code all members’ diagnoses to the highest level of specificity. All encounters for dually eligible members must be submitted to BCPTN.

A sample copy of the Risk Adjustment Medical Record Request letter follows:

To:	<Contact Person>	
Fax:	<Recipient Fax #>	
From:	BlueCross BlueShield of Tennessee	
Re:	Medical Record Retrieval for Medicare Advantage Risk Adjustment Review	
Pages:	<Insert # Pages>	

Request for Medical Records

<Date>

< Office Address>

< City, State Zip>

Dear Practice Manager or Health Information Department:

We are requesting medical records for your BlueCross BlueShield of Tennessee Medicare Advantage patients for **dates of service between Jan. 1, 2025, and now**. Because we are a Medicare Advantage Organization, the Centers for Medicare & Medicaid Services (CMS) requires us to verify that our members' medical records contain documentation supporting diagnoses and related acuities for risk adjustment reasons. Please know this is a medical record review and not a claims payment audit.

To minimize the effort needed to fulfill this CMS requirement, we have technology to support remote access to electronic medical record (EMR) systems. This would allow BlueCross to access the necessary records with minimal administrative support from your medical records staff. If you are interested in making remote EMR arrangements, please call us at **1-855-413-8776**. Sites with 25 or more records requested may qualify for this option.

This is a time-sensitive request. We need these medical records, progress or hospital notes, and any clinical correspondence for the patients in the attached list **within six weeks** of the date of this letter. You may also use one of these alternative options to send your records:

- Upload records through our Secure File Transfer Protocol (SFTP). SFTP lets you upload records in batch to our secure location. Instructions are included with this packet.
- Fax directly to our secure **fax line at 1-833-605-5210**.
- Have a Medical Record Technician **visit your office** to collect medical records. Call **1-855-413-8776** to schedule an appointment. Sites with 100 or more records requested may qualify for this option.
- As a last resort only please, mail to:

BlueCross BlueShield of Tennessee
Risk Adjustment Department
1 Cameron Hill Circle, Building 1.4F61
Chattanooga, TN 37402

We greatly appreciate your attention to this important request. **If you have questions about any of these options, please call us at 1-855-413-8776 Monday through Friday from 8 a.m. to 5 p.m. ET.**

Thank you for your help and your continued partnership.

Sincerely,

BlueCross BlueShield of Tennessee

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Provider Assessment Forms

Annually physicians will be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BCPTN members. This form is located in the Quality Care Rewards web application located on Availity®.

BCPTN will reimburse the service as E/M Code 96160 or 96161. Reimbursement is limited to one PAF per Calendar Year per Member. If multiple providers bill a PAF for the same Member in a Calendar Year, only the first claim will be considered for payment. Subsequent claim submissions will be disallowed.

To receive reimbursement, you must complete the form in its entirety and submit electronically within thirty (30) days by upload in the Quality Care Rewards application in Availity or fax it to 423-591-9504.

It should also be included in your patient's chart as part of his or her permanent record. More information about the PAF program can be found in our Quality+ Partnerships Program Information Guide located at:

https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf

Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) Patient Registration Form

This program is designed to identify when members are in Stage 4 or Stage 5 of CKD. Early detection of CKD and proper management to prevent or slow the progression of the disease improves the overall health and clinical outcomes of seniors while reducing health care costs. The case management program offers education and support for members identified with CKD and End Stage Renal Disease (ESRD). It provides members with tools and support to promote knowledge and self-management of their CKD along with other chronic conditions to resolve barriers to care.

The CMS-2728-U3 form (End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration) can be accessed on the Centers for Medicare & Medicaid website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf>. Fax a completed copy of the CMS-2728-U3 form to us at 1-423-591-9465, Attn: Revenue Reconciliation.

Ensure that you have submitted the CMS-2728-U3 form into the CROWNWeb Data Management system and mail a hard copy of the form to the Social Security Administration.

Forms must be submitted within forty-five (45) days for:

- All patients who initially receive a kidney transplant instead of a course of dialysis
- Patients for whom a regular course of dialysis has been prescribed because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life.
- Beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post-transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.
- Beneficiaries who stopped dialysis for more than 12 months and have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant.
- A patient that has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

Note: You must complete all the mandatory fields for your form to be considered "Complete." Failure to do so will result in an "Incomplete" form. If your form is "Incomplete," we will contact you to gather any missing information.

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XV. Appeals and Grievances

A. Member or Representative Appeals and Grievances

BCPTN has incorporated formal mechanisms to address member concerns and complaints or grievances. Concerns raised by members and providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All member submitted complaints are considered grievances and will be processed through BCPTN's usual grievance procedure described in the section below. Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BCPTN in accordance with its corporate policies. If a member has an inquiry, concern, or complaint regarding any aspect of services received, the member may contact the designated Customer Service Representative of BCPTN to discuss the matter. A member may also submit a written grievance or suggestion for improvement to the Grievance Committee.

A member or representative may appeal an adverse initial decision made by BCPTN concerning payment or medical necessity for a healthcare service. Appeals may include entitlement to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service(s).

For additional information, review The Centers for Medicare & Medicaid Services (CMS) Internet Only Manuals (IOMs) Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (<https://www.cms.gov/medicare/appeals-grievances/managed-care>).

1. Definition of Terms

Appeal: An appeal includes any of the procedures that deal with the review of adverse determinations on the health care services. A member believes he or she is entitled to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by BCPTN and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), reviews by the Medicare Appeals Council (MAC), and judicial review.

Assignee: A non-contracted physician or other non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

Complaint: Any expression of dissatisfaction to BCPTN, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, quality of care and the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Cost Sharing Obligations: Medicare deductibles, premiums, co-payments and coinsurance that the member's assigned MCO is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and Other Medicare/Medicaid Dual Eligibles, TennCare MCO is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under 21 or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.

Dual Eligible: As used in Tennessee, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible ("FBDE").

Dual Eligible Member: An enrollee who is Dual-Eligible and is enrolled in a Plan.

Fully integrated dual eligible member: An enrollee who is eligible to participate in a dual special needs plan that provides access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract with the applicable state.

Effectuation: Compliance with a reversal of the BCPTN original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Encounter: A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

Encounter Data: In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

Full Benefit Dual Eligible (FBDE): An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible and those who qualify as medically needy under the State Plan.

Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which BCPTN or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may make the complaint or dispute, either orally or in writing, to a BCPTN, provider, or facility. An expedited grievance may also include a complaint that BCPTN refused to expedite an organization determination or reconsideration or invoked an extension to an organization determination or reconsideration period.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity (IRE): An independent entity contracted by CMS to review BCPTN and other D-SNPs adverse reconsiderations of organization determinations.

Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received

by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Inquiry: Any oral or written request to BCPTN, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a member. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.

Personally Identifiable Information (PHI): Any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

Protected Health Information/Personally Identifiable Information (PHI/PII): (45 C.F.R. § 160.103; OMB Circular M-06-19 located at <http://www.whitehouse.gov>.

– Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Quality of Care Issue: A quality of care complaint may be filed through the BCPTN HMO D-SNP grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided for BCPTN meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration: A member's first step in the appeal process after an adverse organization determination; BCPTN or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

State Plan: The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare: The medical assistance program administered by Tennessee Department of Finance and Administration, Division of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare MCO: A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

A. Appeals

- BCPTN members or their representatives;
 - Have the right to request an expedited reconsideration
 - The right to request and receive appeal data from BCPTN
 - The right to receive notice when an appeal is forwarded to an Independent Review Entity (IRE)
 - The right to automatic reconsideration by an IRE contracted by CMS, when BCPTN upholds its original adverse determination in whole or in part.
 - The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement;
 - The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part;
 - The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount in controversy meets the appropriate threshold requirement;
 - i. The right to request a QIO review of termination of coverage of inpatient hospital care. If the member receives immediate QIO review of a determination on non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by BCPTN. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Member may submit request for QIO review of determination of non-coverage of inpatient hospital care;
 - ii. The right to request a QIO review of a termination of services in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF). If the member receives a QIO review of the above service termination, the member is not entitled to the additional review of the issue by BCPTN.
 - iii. The right to request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information.
- The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations

(LCDs). Challenges concerning NCDs are to be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The appeal process is available to both members with original Medicare and those enrolled in BCPTN.

Below is a quick reference guide for the processes:

2. Appeal Levels

Level 1 Appeal

BCPTN

Dissatisfied with determination by BCPTN

- Member or representative or treating physician may request an appeal
- Send request for reconsideration to:

BlueCare Plus Member Appeals
1 Cameron Hill Circle Suite 0042
Chattanooga, TN 37402-0042
Fax: 1.888.416.3026

- Request for reconsideration must be within 65 days of initial decision
- Member or representative will be notified:
 - 30 days if the decision involves a request for service
 - 60 days if the decision involves a request for payment
- Expedited Review in Special Circumstances
- A member or physician may request an **expedited reconsideration** by BCPTN in situations where the standard reconsideration time frame might jeopardize the member's health, life, or ability to regain maximum function. Expedited appeal request may be submitted verbally.
- If a member disagrees with BCPTN decision to discharge or discontinue services while the member is receiving inpatient hospital care, skilled nursing facility care, home health care or comprehensive rehabilitation facility care, the member may request an immediate review by a Quality Improvement Organization.
- Automatic Forward to Level 2 Appeal.
 - The member's appeal to and independent outside entity for a Level 2 review. If BCPTN does not meet the response deadline it will forward the appeal to an independent outside entity for a Level 2 review.
 - If during the Level 1 appeal BCPTN does not decide in the member or representative's favor, it is required for BCPTN to forward the case to the independent review entity (IRE).

Level 2 Appeal

Independent Review Entity

Dissatisfied with Reconsideration (Level 1) file Level 2 Appeal

- Independent Review Entity (IRE) (CMS contracted reviewer) conducts the Level 2 appeal (reconsidered determination)

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- Level 1 automatically forwarded to Level 2 IRE of the appeals process if:
 - BCPTN does not meet the response deadline
 - Unfavorable redetermination (fully or partially)
- After the IRE has reviewed the case it will send a notice of its decision in the mail.
 - The IRE notice will include detailed information about the right to appeal to Office of Medicare Hearings and Appeals OMHA (Level 3). You may appeal to Level 3 if:
 - Dissatisfied with IRE decision
 - Amount in controversy is \$190 or more (this amount may change annually)
 - Less than 60 days have passed from reconsideration determination

For fully integrated dual eligible members, the upheld appeal is forwarded also to TennCare. TennCare has the right to overturn an upheld appeal.

Level 3 Appeal

Office of Medicare Hearings and Appeals (OMHA)

- If you disagree with outcome of Reconsidered Determination Level 2 appeal
 - Member or representative can request hearing before the Administrative Law Judge (ALJ)
- This must be filed within 60 days
- ALJ may decide a case on-the-record if a party waives its rights to an oral hearing or in some cases when the documentary evidence supports a finding fully favorable to the appellant.

On Medicaid covered items/services, members are provided the opportunity of a State Fair Hearing on upheld appeals. The state provides the date and time of the hearing.

Level 4 Appeal

Medicare Appeals Council

If the member or representative is not satisfied with the Level 3 decision/dismissal, a review by the Medicare Appeals Council (MAC) may be filed.

- The MAC is part of the Departmental Appeals Board of the Department of Health and Human Services (HHS) and is independent of OMHA and ALJs
- A member may request a Medicare Appeals Council (MAC) with the following information within 60 days:

Beneficiary's name;

Name of the health services provider;

Date and type of service;

Medicare contractor or managed care organization that issued the initial determination in a member's case; Health Insurance Claim Number (HICN);

OMHA appeal number;

Date of the Administrative Law Judge (ALJ) decision or dismissal;

An appointment of representative, such as [CMS Form 1696 \(PDF, 66.4 KB\)](#) (if applicable);

Any additional evidence, clearly marked as new or duplicate; and
Proof that a member provided copies of the request to all other parties.

Submit the request to:

Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, SW, Room G-644
Washington DC 20201
Fax the request to (202) 565-0227

Level 5 Appeal

Federal District Court

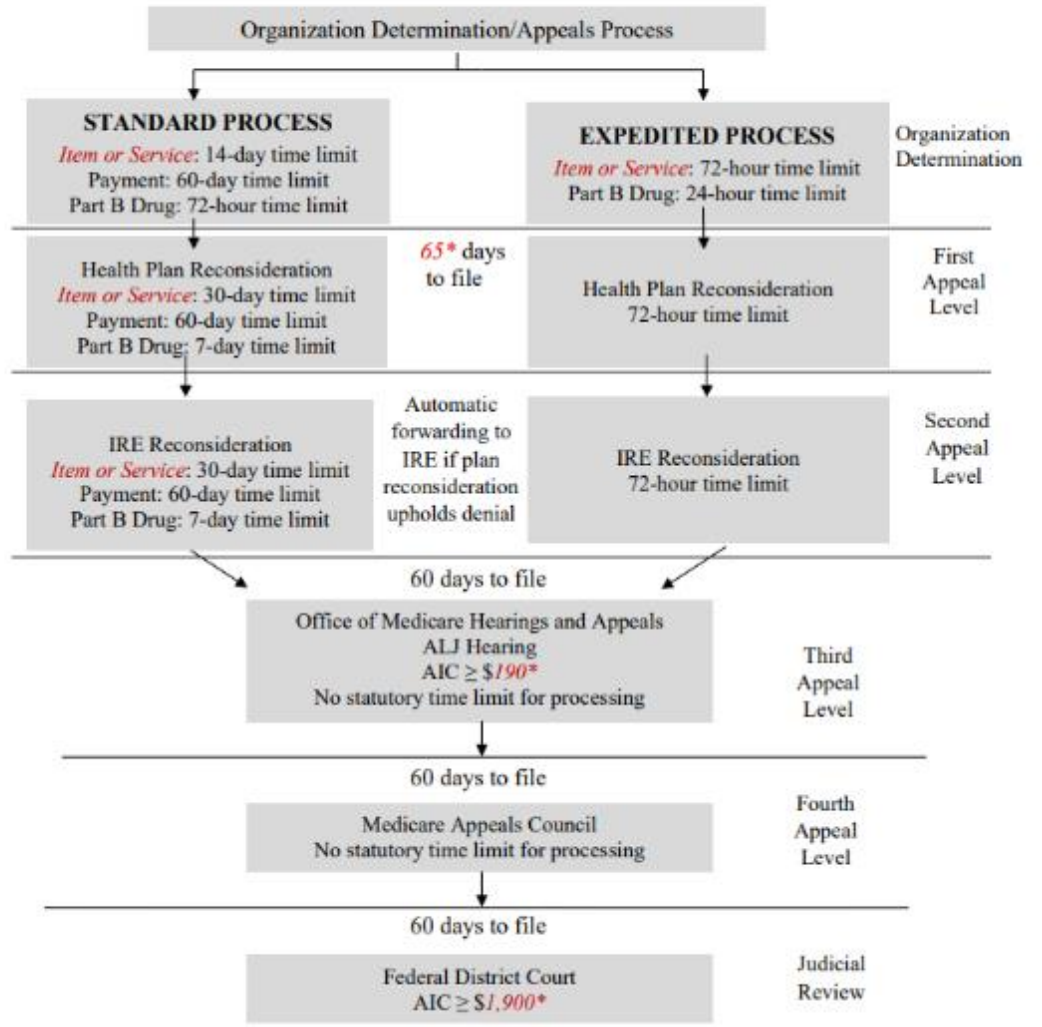
If the member disagrees with the Level 4 decision and the amount in controversy is \$1,900 (the amount may change annually)

- The member or representative may file with the Federal District Court
 - The request must be filed within 60 days of the MAC decision.
- The notice of decision from the MAC will give the member or representative about filing a civil action
 - Last level of appeals

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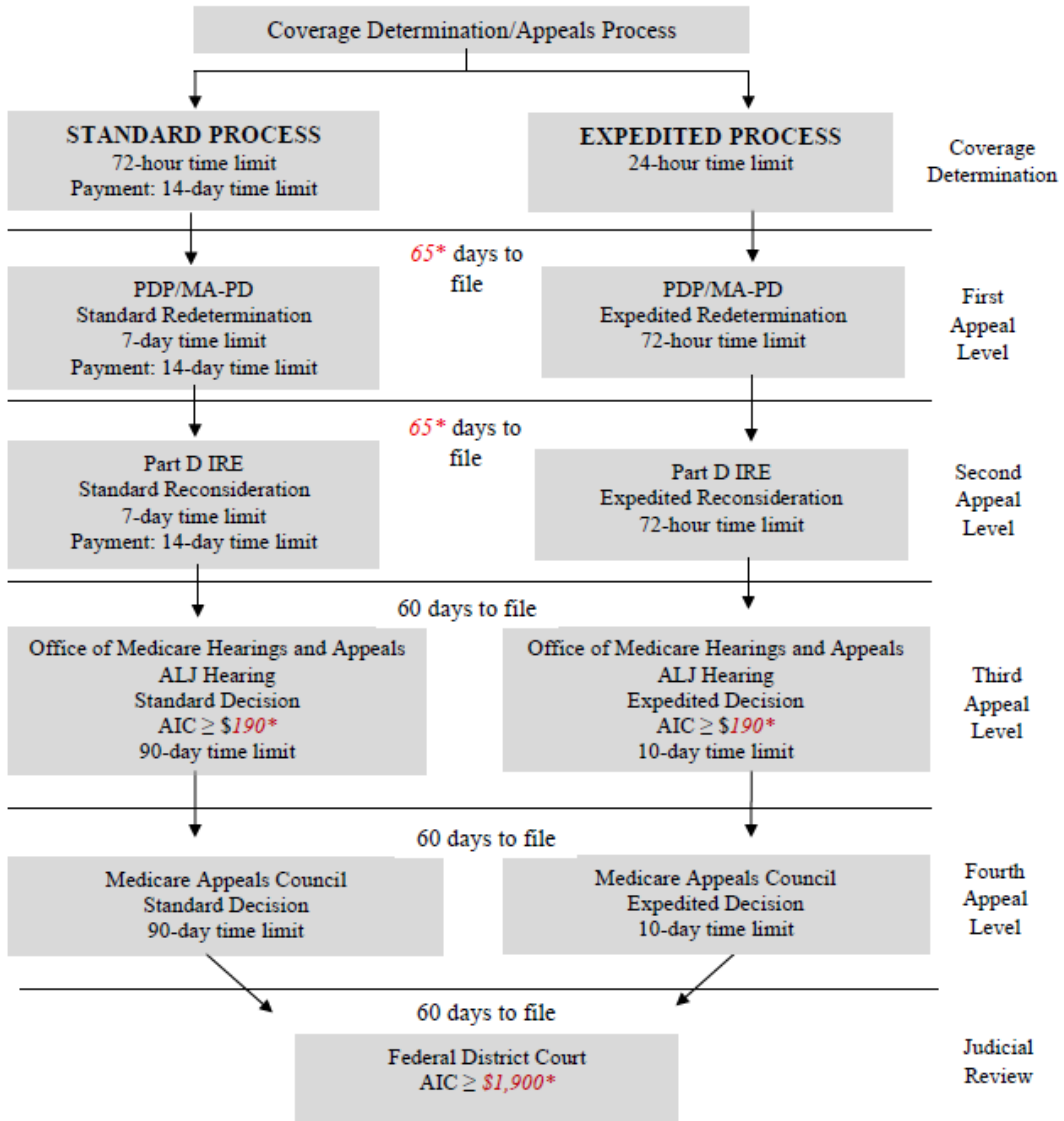
Appendix 1 – Medicare Managed Care (Part C) Appeals Process Overview

Medicare Managed Care (Part C - Medicare Advantage)



Appendix 2 – Medicare Prescription Drug (Part D) Appeals Process Overview

Medicare Prescription Drug (Part D)



3. Representatives Filing on Behalf of Members

Individuals who represent members may either be appointed or authorized (for purposes of this chapter [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as “representatives”) to act on behalf of the member in filing a grievance, requesting an organization determination, or in dealing with any of the levels of the appeals process. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of a member. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney (POA), or a health care proxy, or a person designated under a health care consent statute. Due in part to the incapacitated or legally incompetent status of a member, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee’s authorized representative.

To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form (for purposes of this section, “representative form” means a Form CMS-1696 Appointment of Representative or other equivalent written notice). An “equivalent written notice” is one that:

- Includes the name, address, and telephone number of enrollee;
- Includes the enrollee’s HICN [or Medicare Identifier (ID) Number];
- Includes the name, address, and telephone number of the individual being appointed;
- A written explanation of the purpose and scope of the representation;
- Contains a statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- Is signed and dated by the enrollee making the appointment; and
- Is signed and dated by the individual being appointed as representative and is accompanied by a statement that the individual accepts the appointment.

Either the signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative’s status, must be included with each request for a grievance, an organization determination, or an appeal. Regarding a representative appointed by a member, unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of a grievance, a request for organization determination, or an appeal. A photocopy of the signed representative form must be submitted with future grievances, requests for organization determinations, or appeals on behalf of the enrollee in order to continue representation. However, the photocopied form is only good for one year after the date of the enrollee’s signature. Any grievance, request for organization determination, or appeal received with a photocopied representative form that is more than one year old is invalid to appoint that person as a representative and a new representative form must be executed by a member.

Please note that the OMB-approved Form CMS-1696, Appointment of Representative (AOR) contains the necessary elements and conforms to the Privacy Act requirements and is preferred. For purposes of the Medicare health plan disseminating the AOR form, the most current edition must be used and prior versions of Form CMS-1696 are obsolete. Please note that only sections I, II, and III of the form apply to the Medicare Advantage program. Medicare health plans may not require appointment standards beyond those included in the CMS form.

Note: The CMS-1696 form, as written, applies to all Title XVIII Medicare benefits. However, a valid appointment of representative form submitted with a request that specifically limits the appointment to Part D prescription drug benefits is not valid for requests that involve Medicare Advantage (MA) benefits. In this situation, a member must properly execute a separate representative form if he or she wishes the Part D representative to also serve as his or her MA representative (or vice versa). If a representative (who is representing a member in regards to a Part D claim) files a MA grievance or requests an organization determination or appeal without a newly executed representative form, the Medicare health plan should explain to the representative that a new representative form must be executed, and provide the representative with a reasonable opportunity to submit the new form before dismissing the request.

4. Authority of a Representative

Unless otherwise stated in the 42 CFR subpart M of part 422, the representative has all the rights and responsibilities of a member in filing a grievance, obtaining an organization determination, or in dealing with any of the levels of the appeals process. On behalf of the member the representative can;

- Obtain information about the member's claim to the extent consistent with Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request or give or receive any notice about the proceedings

All notices intended for the member must be sent to the member's representative instead of the member.

Details for the Form: CMS 1696 can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html>.

CMS 1696 Appointment of Representative

For Spanish version visit The Centers for Medicare and Medicaid [Forms](#) page.

5. Complaints

Complaints may include both grievances and appeals. They may be processed as an appeal or as a grievance or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations.

6. Non-contract Provider Appeals

A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability (WOL) statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.

7. Re-openings and Revising Determinations and Decisions

A reopening is a remedial action to change a final determination or decision even though the determination or decision was correct based on the evidence of record. The action may be taken by the following;

- BCPTN to revise the organization determination or reconsideration

- An IRE to revise the reconsidered determination.
- TennCare to revise the determination
- An ALJ to revise the hearing decision
- The MAC to revise the hearing or review decision

BCPTN processes clerical including minor errors and omissions as reopening rather than reconsiderations. If, however, a request for reopening is submitted and after review determined that the issue is not an error, the reopening request will be dismissed and the member or representative will be advised of any appeal rights, provided the timeframe to request an appeal on the original claim has not expired.

Examples of errors may include mathematical or computational mistakes, inaccurate data entry or denials of claims as duplicates.

According to CMS regulations, BCPTN must process clerical errors, minor errors and omissions as a reopening.

The following are guidelines for submitting a reopening request;

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the reason for requesting a reopening; and
- The request should be made within the time frames permitted;

8. Re-opening Timeframes

- Within 1 year from the date of the organization determination or reconsideration for any reason;
- Within 4 years from the date of the organization determination or reconsideration for good cause;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;
- At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

Resource

Additional information for the appeals process is available at <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf>.

B. Provider Dispute Resolution

Purpose: To address and resolve any and all matters causing **participating** providers (“providers”) or BlueCross BlueShield of Tennessee or its affiliated companies (“BCBST”) to be dissatisfied with any aspect of their relationship with the other party (a “Dispute”). Providers are encouraged to contact a representative of BlueCross BlueShield of Tennessee’s Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

*Non-contracted, non-participating, and out-of-state providers may also utilize the PDRP pursuant to the terms hereof and in accordance with BCBST policy.

****NOTE:** If the service/item has not been provided to a member and the provider wishes to appeal a denial, the member appeals process as noted above is to be used for timely filing and processing.

Introduction.

A. This Procedure describes the exclusive method of resolving any Disputes related to a provider's participation in BCBST's network(s). It is incorporated by reference into the participation agreement between the parties (the "Participation Agreement") and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BCBST's or the provider's control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party's control (e.g., determinations made by a customer purchasing administrative services only ("ASO Customers") from BCBST).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant's professional qualifications, conduct or competence must be resolved pursuant to BCBST's "Medical Management Corrective Action Plan" (Section XI.D).

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g. the date of the letter informing the provider of a determination) or, with respect to a provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the provider received payment or, in the event of unpaid claim, the date the provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the provider's agreement(s) with BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit which is in progress at the end of the eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES' SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.

DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION.

Providers should contact a representative of the BCBST 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 claim 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 BCBST representative. BCBST 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.

Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee, and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant's demand individually and shall not certify or consider multiple claimants' demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association

(most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

D. EFFECTIVE DATE.

This procedure statement was adopted by BCBST on June 1, 1997.

Note: The former Provider Dispute Form has been replaced with the following fillable forms located on BCPTN Tennessee website: Provider Reconsideration Form

Provider Reconsideration Form and the Provider Appeal Form are located at www.bcbst.com/providers/forms/reconsideration-and-appeals.page.

C. BlueCare Plus Choice Reportable Event Management

Reportable Event Management (REM) Requirements

In HCBS programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, BlueCare, and the Department of Disability and Aging (DDA), as outlined in the REM Operational Protocol.

Providers are to comply with the requirements specified in the REM Protocol and Definitions document. Reportable Events must be submitted to the Department of Disability and Aging by the close of the next business day after witness or discovery of the event. The event must be submitted via electronic form at <https://stateoftennessee-cvlyz.formstack.com/forms/ref> . Tier 1 Reportable Events must also be reported to DDA's Abuse Hotline (1-888-633-1313) as soon as possible, but no later than four hours after the occurrence of the event or the discovery thereof and shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS) and/or law enforcement, as required by law.

For any Reportable Event, the provider shall have supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Reportable Behavioral Events, this may include follow up with the member's PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the person's Care Coordinator, Support Coordinator, Independent Support Coordinator, or DDA Case Manager regarding any needed adjustments in the Person Centered Support Plan, and targeted training or assistance for agency staff who support the person. All Reportable Events, any medical attention provided and follow up shall be documented in the member's record.

Further information on REM can be found on the TN.gov website at: [Reportable Event Management \(REM\) \(tn.gov\)](http://www.tn.gov/Reportable-Event-Management-REM)

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XVI. Provider Manual Change Document

Provider Manual Update

Update 20260401

Correction	Page	Description
20260401.01	1	Updated Cover Page/Cover Art
20260401.02	2-8	Updated Table of Contents
20260401.03	15-19	II. Administrative B. Compliance <ul style="list-style-type: none"> Updated weblink under - Protected Health Information-allowable disclosures under HIPAA
20260401.04	25-26	III. Member Enrollment B. Member ID Cards <ul style="list-style-type: none"> Updated images of the BlueCare Plus Insurance Cards
20260401.05	29-77	IV. Provider Requirements A. Provider Networks <ul style="list-style-type: none"> Removal of Providers from BCBST/BCPTN Provider Network Added a sentence to the second to last paragraph. B. Provider Credentialing <ul style="list-style-type: none"> Major languages changes throughout the entire section 1. Introduction <ul style="list-style-type: none"> Updated the email address C. Credentialing Policy <ul style="list-style-type: none"> Major languages changes throughout the entire section Removed multiple provider types and what is required for credentialing Added multiple provider types and what is required for credentialing Updated what is needed for multiple provider types and what is required for credentialing E. Provider Resources <ul style="list-style-type: none"> 6. BCPTN Provider Website

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		<ul style="list-style-type: none"> Reworded the first paragraph under the Provider Resource Page section
20260401.06	84-97	<p>V. General Guidelines for Benefits</p> <p>I. Behavioral Health Service</p> <ul style="list-style-type: none"> Reworded a lot of the language under the Reporting Behavioral Health Adverse Occurrences to BCPTN section Added a bullet point to Examples of reportable adverse occurrences include, but are not limited to the following: <p>J. Dental</p> <ul style="list-style-type: none"> Updated BCPTN to Dental Benefit Providers Added language under Comprehensive Services <p>N. Over the Counter (OTC)</p> <ul style="list-style-type: none"> Updated dates to 2026 within the section <p>S. Vision Services</p> <ul style="list-style-type: none"> Added language to the first sentence Removed language from the first bullet point of the section Added a section titled Vision Frequently Asked Questions
20260401.07	101-103	<p>VII. Pharmacy</p> <ul style="list-style-type: none"> Updated hyperlink
20260401.08	118-140	<p>X. Utilization Management</p> <p>D. Prior Authorization</p> <ul style="list-style-type: none"> Updated hyperlink Added a section titled Vendor Authorized Partnership Removed a section with bullet points on when prior authorization is required when performed in an inpatient or outpatient setting Removed a bullet point under Home Health Services not normally <p>L. Provider Appeal</p> <ul style="list-style-type: none"> Changed language in the third paragraph
20260401.09	144-147	<p>XI. Quality Improvement Program</p> <p>C. STARS</p> <ul style="list-style-type: none"> Updated STAR Rating

		<ul style="list-style-type: none"> Updated the date to 2026 in the language Updated the hyperlink <p>D. Quality Incentive Program</p> <ul style="list-style-type: none"> Updated the graphic for 2026 Updated the ate to 2026 in the language
20260401.10	161-176	<p>XII. Billing and Reimbursement</p> <p>B. Health Insurance Form CMS-1500</p> <ul style="list-style-type: none"> Added 2 bullet points to the General Instructions sections <p>C. CMS 1450 Facility Claim Form</p> <ul style="list-style-type: none"> Added a note under the General Instructions section
20260401.11	195-200	<p>XIV Risk Adjustments</p> <ul style="list-style-type: none"> Updated dates in the Risk Adjustment Data section
20260401.12	9-215	Updated and corrected multiple grammar, punctuation and word choice errors throughout the document.

Update 20260101

Correction	Page	Description
20260101.01	1	Updated Cover Page/Cover Art
20260101.02	2-8	Updated Table of Contents
20260101.03	9 10 12	<p>I. Introduction</p> <ul style="list-style-type: none"> Updated language in 1st and 2nd paragraphs. <p>B. Code of Business Conduct</p> <ul style="list-style-type: none"> Updated hyperlink in 4th paragraph. <p>D, Statutory and Regulatory History</p> <p>2. Special Needs Plan</p> <ul style="list-style-type: none"> Updated language in last paragraph.
20260101.04	13 14 20	<p>II. Administrative</p> <p>A. General Information</p> <ul style="list-style-type: none"> Updated “Fax Line” number 3. Important Contact Information – Removed language from grid header as it was there in error. Added it back above the grid as a paragraph. <p>C. Coordination of Benefits, Medicare Secondary Payer and Third Party Liability</p> <ul style="list-style-type: none"> Updated language in 5th set of bullets/last bullet
20260101.05	23-24	<p>III. Member Enrollment</p> <ul style="list-style-type: none"> Updated language throughout introductory section.

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	<p>24-25 25 26</p> <p>27-29</p> <p>31</p>	<p>A. Summary of Benefits</p> <ul style="list-style-type: none"> • Made grammatical corrections in 3rd paragraph. • Added new language as 5th paragraph. • Updated year to 2026 within 2025 BCPTN Benefits grid <p>B. Member ID Cards</p> <ul style="list-style-type: none"> • Added clarity language before each set of ID cards and updated ID card samples. <p>C. Primary Care Provider (PCP)</p> <ul style="list-style-type: none"> • Made grammatical correction to last bullet/language and Fax details below it.
<p>20260101.06</p>	<p>32</p> <p>34</p> <p>45</p> <p>47-57</p> <p>58</p> <p>59-62</p> <p>75</p> <p>84</p>	<p>IV. Provider Requirements</p> <p>A. Provider Networks</p> <p>1. Network Participation Criteria</p> <ul style="list-style-type: none"> • Removed “one of” from language in 1st paragraph. • 7. Wait times – added clarity language to Routine & Urgent bullets <p>B. Provider Credentialing</p> <ul style="list-style-type: none"> • 1. Introduction – Added language to 2nd paragraph. <p>C. Credentialing Policies</p> <ul style="list-style-type: none"> • Credentialing Process for Practitioner (Medical and Behavioral Health) – Updated and added language as needed to list for Specific Requirements for Specialties. • 1. Credentialing Process for Medical and Behavioral Health Organizational Providers <ul style="list-style-type: none"> ○ Added “UCAOA/CAUCQ” to 4th bullet within list of information that must be verified. ○ Updated requirements list for On-Site Clinics, Opioid Treatment Program, & Urgent Care Centers. • 4. Accrediting Bodies We Recognize – Added CAUCQ. <p>E. Provider Resources</p> <ul style="list-style-type: none"> • Updated image for BCPTN Homepage
<p>20260101.07</p>	<p>87</p> <p>88</p> <p>89</p> <p>90</p> <p>99-100</p> <p>103</p> <p>103</p> <p>103</p>	<p>V. General Guidelines for Benefits</p> <ul style="list-style-type: none"> • Added 4th paragraph language and bulleted list with a Note underneath. • Removed language from end of 8th paragraph. <p>B. Services, Supplies and Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> • Continuous Glucose Monitors Covered Under Part B – removed language. • Coverage of Supplies and Accessories – Updated language in 2nd paragraph. <p>J. Dental</p> <ul style="list-style-type: none"> • Updated language within 2nd paragraph Note and under Comprehensive Services. <p>M. Hearing Services</p> <ul style="list-style-type: none"> • Removed language regarding effective date for Flexcard hearing benefits. <p>N. Over the Counter (OTC)</p> <ul style="list-style-type: none"> • Removed language in 1st paragraph • Over the counter (OTC) Items/Health Food/Housing Utilities <ul style="list-style-type: none"> ○ Removed “House Utilities” from title

	103	<ul style="list-style-type: none"> ○ Updated language.
	104	<p>O. Podiatry Services</p> <ul style="list-style-type: none"> • Added language to 3rd bullet
	104	<p>Q. Pulmonary Rehabilitation Services</p> <ul style="list-style-type: none"> • Added language to last sentence.
	104	<p>R. Transportation</p> <ul style="list-style-type: none"> • Removed BlueCare Plus title and language. • Removed BlueCare Plus Select title and language. • BlueCare Plus Choice – Removed title and updated language.
	104	
	104	
	105	<p>S. Vision Services</p> <ul style="list-style-type: none"> • Changed \$500 to \$400 in 1st paragraph.
20260101.08	107	<p>VI. Non-Covered Benefits</p> <p>A. General Exclusions</p> <ul style="list-style-type: none"> • Added language to 1st paragraph, Removed Note after bulleted list, and added language as last paragraph
20260101.09	109	<p>VII. Pharmacy</p> <ul style="list-style-type: none"> • Updated hyperlink for 2026
	111	<p>B. Identification Card (ID)</p> <ul style="list-style-type: none"> • Corrected Section from “C” to “B”
20260101.10	116	<p>VIII. Mode of Care (MOC) D-SNP</p> <p>I. Interdisciplinary Care Team (ICT)</p> <ul style="list-style-type: none"> • Deleted 8th bullet/language
20260101.11	121	<p>IX. Care Management</p> <ul style="list-style-type: none"> • Deleted 3rd bullet from 1st list
20260101.12	125	<p>X. Utilization Management</p> <p>A. Utilization Management Guidelines</p> <ul style="list-style-type: none"> • Added language to 7th paragraph.
	126	<p>C. Advance Determination</p> <ul style="list-style-type: none"> • Added “electronically or “ to language.
	127	<p>D. Prior Authorization</p> <ul style="list-style-type: none"> • Added language to 4th paragraph.
	136	<p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> • Emergency Admission – added “fax” to 3rd paragraph. • Observation Stays – Added Inpatient” to 2nd paragraph. • Home Health Services – Added Note at end.
	136	
	138	
	144-145	<p>J. Review Timeframes</p> <ul style="list-style-type: none"> • Organization determination types – Updated language to types as applicable.
	146-148	<p>L Provider Appeal</p> <ul style="list-style-type: none"> • Peer-to-Peer and Re-Evaluation Processes – Updated language in 2nd, 7th, 12th & 13th paragraphs.
20260101.13	151	<p>XI. Quality Improvement Program</p> <ul style="list-style-type: none"> • Updated language in 3rd paragraph.
20260101.14	158	<p>XII. Billing and Reimbursement</p> <p>A. Claims Processing</p> <ul style="list-style-type: none"> • Updated language in 2nd paragraph • 6. Corrected Bills – Updated language as needed. • 8. Code Edits – Added 2nd bulle for OCE
	160-161	
	162	

	164 164-165 170 171	<ul style="list-style-type: none"> 10. Same Day E&M & Preventive Medicine Exam Payment Policy – Added CPT codes and updated eff. Date. 11. Discontinued & Reduced Services/Procedures – Updated language. 12. DMEPOS – Added note to end of sub-section. <p>B. Health Insurance Form CMS-1500</p> <ul style="list-style-type: none"> Updated language in 2nd paragraph.
20260101.15	202	<p>XIII. Remittance Advice</p> <ul style="list-style-type: none"> Within “Payment information” Grid – Updated language for Patient COINS
20260101.16	215 221 224	<p>XV. Appeals and Grievances</p> <p>A. Member or Representative Appeals and Grievances</p> <ul style="list-style-type: none"> 2. Appeal Levels, Level 2 Appeal & Level 3 Appeal - Added bullet/language to end of each section 7. Re-Openings and Revising Determinations and Decisions – Added bullet #3 to first bulleted list <p>C. BlueCare Plus Choice Reportable Event Management</p> <ul style="list-style-type: none"> REM Requirements – Added language to 1st paragraph.

Update 20251001

Correction	Page	Description
20251001.01	2-8	Update Table of Contents
20251001.02	158	<p>XII: Billing and Reimbursement</p> <p>10. Same Day Evaluation and Management (E&M) and Preventative Medicine Exam Payment Policy</p> <ul style="list-style-type: none"> Updated this entire section

Update 20251001

Correction	Page	Description
20251001.01	Cover	Updated Cover Page/Cover Art
20251001.02	2-8	Updated Table of Contents
20251001.03	9-218	BlueCare Plus Tennessee was changed to BCPTN and DIDD was changed to DDA throughout the document.
20251001.04	9-12	<p>I. Introduction</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section.

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20251001.05	13-21	<p>II. Administrative</p> <ul style="list-style-type: none"> • Corrected grammatic errors throughout the section. <p>B. Compliance</p> <ol style="list-style-type: none"> 3. False Claims Act <ul style="list-style-type: none"> • Added a bullet point. • Reworded the paragraph under Improper Benefits 5. Reworded number 3 under Deficit Reduction Act of 2025.
20251001.06	28-80	<p>IV. Provider Requirements</p> <ul style="list-style-type: none"> • Corrected grammatic errors throughout the section. <p>A. Provider Networks</p> <ul style="list-style-type: none"> • Added a paragraph <ol style="list-style-type: none"> 1. Network Participation Criteria <ul style="list-style-type: none"> • Multiple bullet points reworded through the sections. • Member phone call after hours section removed. • New paragraphs added under wait times section. • Removed sections 5 and 6 under XII General Provisions: 2. Changes in Practice <ul style="list-style-type: none"> • The first bullet point was reworded <p>B. Provider Credentialing</p> <ol style="list-style-type: none"> 1. Introduction <ul style="list-style-type: none"> • Second paragraph removed 2. Credentialing application <ul style="list-style-type: none"> • Multiple bullet points removed or reworded under this section. • Sentence added to Electronic Funds Transfer (EFT): <p>C. Credentialing Policies</p> <ul style="list-style-type: none"> • Multiple bullet points removed under Credentialing Process for Practitioner: (Medical and Behavioral Health) • One bullet point added <ol style="list-style-type: none"> 1. Credentialing Process for Medical and Behavioral Organizational Providers <ul style="list-style-type: none"> • Multiple bullets added and/or removed for most specialties throughout the section • Removed specialty: Nurse Practitioner – Working at an On Site Clinic • Removed Specialty: On Site Clinical Provider – MD and DO’s

		<ul style="list-style-type: none"> • Removed Specialty Physician Assistant – Working in an Onsite Clinic as a Physician Assistant <p>2. Recredentialing Process</p> <ul style="list-style-type: none"> • Removed the last paragraph Practice Site/Medical Record Standards • Removed number 20 <p>D. Electronic Data Interchange (EDI)</p> <p>1. Filing Electronic Claims</p> <ul style="list-style-type: none"> • Corrected the link under Provider Number/National Provider Identifier (NPI) Number for Electronic Claims: •
20251001.07	81-100	<p>V. General Guidelines for Benefits</p> <ul style="list-style-type: none"> • Corrected grammatic errors throughout the section <p>I. Behavioral Health Services</p> <p>7. Treatment Record Requirements</p> <ul style="list-style-type: none"> • Removed the section: Behavioral Health Quality of Care and Adverse Occurrence
20251001.08	106-113	<p>VIII. Model of Care (MOC) D-SNP</p> <ul style="list-style-type: none"> • Grammatic changes throughout this section
20251001.09	119-144	<p>X. Utilization Management</p> <ul style="list-style-type: none"> • Grammatic changes throughout the section <p>D. Prior Authorization</p> <ul style="list-style-type: none"> • Reworded a bullet point under: Additional prior authorization requirements for BlueCare Plus Choice members include: <p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> • Reworded heading i. 31-Day Readmission Quality Program • Removed a bullet point under: i. 31-Day Readmission Quality Program • Reworded the paragraph under: Lifetime Reserve Days • Removed a bullet point under: Ambulatory Surgeries section <p>L. Provider Appeals</p> <ul style="list-style-type: none"> • Corrected a time frame in the section multiple times • Language change in a paragraph
20251001.10	145-150	<p>XI. Quality Improvement Program</p> <p>D. Quality Incentive Program</p> <ul style="list-style-type: none"> • Updated to a 2025 graphic • Updated the year to 2025 in the last paragraph
20251001.11	151-194	<p>XII. Billing and Reimbursement</p> <p>A. Claims Process</p>

		8. Code Edits <ul style="list-style-type: none"> • Added a hyperlink 9. New Section Added – Sexually Transmitted Infection Testing 10. New Section Added – Same Day Evaluations & Management (E&M) and Preventive Medicine Exam Payment Policy 11. New Section Added – Discontinue and Reduced Services/Procedures (Modifier 52, 53, 73, 74)
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Update 20250715

Correction	Page	Description
20250715.01	Cover	Updated Cover Page/Cover Art
20250715.02	2-8	Updated Table of Contents
20250715.03	22-27	III. Member Enrollment <ul style="list-style-type: none"> • Corrected grammatic errors throughout the section. C. Primary Care Provider (PCP) <ul style="list-style-type: none"> • Added “Option 2” to the phone number provided. • Corrected bullet 3 under, “The Primary Care Provider change is considered initiated when:” • Updated the language under “The Primary Care Provider change is considered initiated when:” to direct the provider to use Availity for PCP changes for BlueCare Plus.
20250715.04	28-83	IV. Provider Requirements <ul style="list-style-type: none"> • Corrected grammatic errors throughout the section. • Credentialing Policies • Removed two bullet points under, “Addiction Medicine Addictionologist (Buprenorphine – based therapy for medication assisted treatment of substance use disorder)” • Reworded the first sentence under, “Certified Registered Nurse Anesthetist (CRNA)” • Reworded a bullet point under, “Dentist - Pediatric Dentist”

		<ul style="list-style-type: none"> • Removed a bullet point under, “Nurse Practitioners or Nurse Mid-Wife” • Removed a bullet point under, “Nurse Practitioner – Master’s Clinical Nurse Specialist/Psychiatric Nurse” • Removed a bullet point under, “Nurse Practitioner – Working at an On-Site Clinic” • Removed several bullet points under, “Nurse Practitioner – Working in a Pain Management Setting” • Removed several bullet points under, “Nurse Practitioner – Working in the Urgent Care Setting” • Reworded a bullet point under, “Pain Management” • Reworded the heading, “Physical Therapist/Occupational Therapist” • Added a bullet under, “Physician Assistant – Working in an Onsite Clinic Licensed as a Physician Assistant” • Reworded a bullet point under, “Pain Management” • Reworded the heading, “Physician Assistant - Surgical Assist: (Specialist)” and removed (Specialist) • Removed a bullet point, “Physician Assistant - Surgical Assist” • Removed a bullet point under, “Physician Assistant - Working the Urgent Care Setting” • Reworded a bullet point under, “Podiatrist – Foot and Ankle Surgery” • Reworded multiple bullet points under, “Acute Care Facility Hospital” • Reworded a bullet point under, “Ambulatory Infusion Center (AIC)” • Reworded a bullet point under, “Professional Support Services Licensure (PSSL)” • Removed multiple bullet points under, “Psychiatric Hospital” • Added a bullet point under, “Supportive Housing”
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		<p>4. Accrediting Bodies We Recognize</p> <ul style="list-style-type: none"> Removed a bullet point
20250715.05	84-103	<p>V. General Guidelines for Benefits</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section. <p>B. Services, Supplies and Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> Reworded the paragraph under, “Continuous Glucose Monitors Covered Under Part B” <p>D. Part B Drugs</p> <ul style="list-style-type: none"> Updated the second hyperlink in the section. <p>I. Behavioral Health Services</p> <ul style="list-style-type: none"> Removed Section 7. Credentialing Process for Behavioral Health Providers Reworded the heading, “Behavioral Health Quality Management” – Now Behavioral Health Quality Management of Care and Adverse Occurrences Reworded the paragraph under, “Complaints and Quality of Care Concerns” Removed the section headed “Site Visits for Quality Reviews and Quality Improvement Activities.
20250715.06	122-145	<p>X. Utilization Management</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section. <p>A. Utilization Management Guidelines</p> <ul style="list-style-type: none"> Update the link <p>B. Organization Determination</p> <ul style="list-style-type: none"> Reworded this section Removed a bullet point <p>C. Advanced Determination</p> <ul style="list-style-type: none"> Reworded this section <p>D. Prior Authorization</p> <ul style="list-style-type: none"> Reworded this section

		<ul style="list-style-type: none"> Removed multiple bullet points <p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> Reworded multiple paragraphs in this section Removed multiple bullet points within the section Added multiple paragraphs in this section <p>L. Provider Appeal</p> <ul style="list-style-type: none"> Reworded multiple paragraphs in this section <p>M. Reopening</p> <ul style="list-style-type: none"> Reworded the third paragraph
20250715.07	152-191	<p>XII. Billing and Reimbursement</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section. <p>D. Institutional Claim Billing and Reimbursement Guidelines</p> <p>6. Readmission Quality Program</p> <ul style="list-style-type: none"> Reworded multiple paragraphs in this section Removed multiple bullet points within this section Added multiple paragraphs in this section <p>14. Home Health Services</p> <ul style="list-style-type: none"> Updated multiple billing codes in the second and third table in the section
20250715.08	197-199	<p>XIV. Risk Adjustment</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section. <p>3. Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:</p> <ul style="list-style-type: none"> Removed multiple bullet point under heading, "Provider Signature Requirements on Progress Note" <p>4. Releasing Medical Records</p> <ul style="list-style-type: none"> Removed the information of where medical records can be mailed, faxed or collected from <p>6. Risk Adjustment Data</p> <ul style="list-style-type: none"> Corrected the wording of multiple paragraphs in the section Removed the example of the letter

		<ul style="list-style-type: none"> Added a sample email letter
20250715.09	203-217	<p>XV. Appeals and Grievances</p> <p>A. Member or Representative Appeals and Grievances</p> <ul style="list-style-type: none"> Reworded the first paragraph. <p>1. Definition of Terms</p> <ul style="list-style-type: none"> Added a paragraph <p>2. Appeal Level</p> <ul style="list-style-type: none"> Reworded the last bullet under Level 1 Appeal Changed the controversy amount to \$190 under Level 2 Appeal Changed the controversy amount to \$1900 under Level 5 Appeal <p>6. Organization Determination (Section Removed)</p>

Update 20250401

Correction	Page	Description
20250401.01	Cover	Updated Cover Page/Cover Art
20250401.02	2-8	Updated Table of Contents
20250401.03	9-12	<p>I. Introduction</p> <ul style="list-style-type: none"> Corrected grammatic errors throughout the section. Updated abbreviation from (D-SNP) to (HMO D-SNP) Corrected that there are three plan options, not two. Corrected “BlueCare Plus” to “BlueCare Plus Tennessee”
20250401.04	13-21	<p>II. Administration</p> <ul style="list-style-type: none"> Corrected grammatic errors and formatting throughout the section. Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>C. Coordination of Benefits, Medicare Secondary Payer and Third Party Liability</p> <ul style="list-style-type: none"> Added a bullet stating: “When a service is non-covered by BCPTN and the member is eligible with Medicaid, submit the claim with the BCPTN EOB to the Member’s assigned MCO. When a member’s

		Part A benefits are exhausted, the MCO will require a copy of the Part A and Part B EOBs in order to determine appropriate reimbursement.”
20250401.05	22-28	<p>III. Member Enrollment</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section.
20250401.06	29-83	<p>IV. Provider Requirements</p> <ul style="list-style-type: none"> • Corrected grammatic errors, rewording of multiple paragraphs and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>A. Provider Networks</p> <ul style="list-style-type: none"> • Corrected the third paragraph (turning it into 4 paragraphs.) <p>1. Network Participation Criteria</p> <ul style="list-style-type: none"> • Under VII removing Primary Care and Specialist and Hospital Based information. • Under IX added 3. Seven-day; 24 hours coverage through participating providers required • Under XII removed 11 and 12 • Under XII 12 added additional rational under, “Provider or its owner/board member or managing partner has not:” <p>2. Changes in Practice</p> <ul style="list-style-type: none"> • Added 2 bullet points to the end. <p>5. Provider Termination Appeal Process</p> <ul style="list-style-type: none"> • Corrected the wording of the first paragraph. <p>6. Federal Exclusion Screening Requirements</p> <ul style="list-style-type: none"> • Added a section titled: RECOUPMENT OF CLAIMS PAID TO OR FOR THE BENEFIT OF EXCLUDED PROVIDER <p>A. Credentialing Policies</p> <ul style="list-style-type: none"> • Removed the first two sentences under Anesthesiologist • Reworded the fourth bullet under Dermatology • Reworded the fifth bullet under Nurse Practitioners or Nurse Mid-Wife

		<ul style="list-style-type: none"> • Reworded the fourth bullet under Nurse Practitioner – Master’s Clinical Nurse Specialist/Psychiatric Nurse • Reworded the heading Nurse Practitioner – Working at an On-Site Clinic (DELETED Premise, Sanitas, McKee, etc) • Reworded the fourth bullet under Nurse Practitioner – Working in a Pain Management Setting • Reworded the heading On-Site Clinic Providers – MD and DO’s DELETED(Primary Care) – (Example – Premise Health, Sanitas, McKee, etc.) • Reworded the second bullet under On-Site Clinic Providers – MD and DO’s • Reworded seventh bullet under Obstetrics and Gynecology • Completely removed On-Site Clinic Providers – MD and DO’s (Specialist) – (Example – Premise Health, Sanitas, McKee, etc.) section • Reworded section Physician Assistant – Working in an Onsite Clinic DELETED (Premise, Sanitas, McKee, etc) • Reworded the heading Urgent Care Providers - MD and DO’s – DELETED (Primary Care and Specialist) – Note Urgent Care will not be listed as the specialty, the specialty in Cactus will match the providers education (Urgent Care is the setting that they are practicing in, not the actual specialty) • Added a new bullet under Urgent Care Providers - MD and DO’s • Reworded the third bullet under Professional Support Services Licensure (PSSL) • Removed fifth bullet under Psychosocial Rehabilitation Center
20250401.07	84-104	<p>V. General Guidelines for Benefits</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section.

		<p>R. Transportation</p> <ul style="list-style-type: none"> • Reworded the paragraph under BlueCare Plus Choice • Reworded the paragraph under BlueCare Plus Select
20250401.08	110-117	<p>VIII Model of Care (MOC) D-SNP</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section.
20250401.09	118-122	<p>IX. Care Management</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>H. End of Life Planning – Removed Section</p>
20250401.10	123-148	<p>X. Utilization Management</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> • Added a sentence to the eighth paragraph. • Added a new paragraph stating: Retrospective concurrent review is performed on outlier payments only for acute inpatient admissions. • Added a section titled: Inpatient DRG Outlier Program Management Program <p>J. Review Timeframes</p> <ul style="list-style-type: none"> • Added a sentence to the Expedited organization determinations paragraph. • Added a sentence to the Expedited organization determination for Part B drugs paragraph <p>K. Mandated Notices</p> <p>C. Notice of Medicare Non-Coverage (NOMNC):</p> <ul style="list-style-type: none"> • Reworded this entire section. <p>L. Provider Appeal</p> <ul style="list-style-type: none"> • Reworded this entire section
20250401.11	149-153	<p>XI. Quality Improvement Program</p> <ul style="list-style-type: none"> • Corrected grammatic errors and formatting throughout the section. • Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>C. STARS</p> <ul style="list-style-type: none"> • Updated the starts rating to 4.5 in paragraph one. • Updated the hyperlink under TIPS FOR PROVIDERS

		<ul style="list-style-type: none"> Changed the year to 2023 under TIPS FOR PROVIDERS in the sentence: Table 1 lists the contract year 2023 organization types and whether they are included in the Part C and/or Part D Plan Ratings.
20250401.12	154-196	<p>XII. Billing and Reimbursement</p> <ul style="list-style-type: none"> Corrected grammatic errors and formatting throughout the section. Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. Duplicate codes in the table following the sentence, “The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:” were removed.
20250401.13	200-205	<p>XIV. Risk Adjustment</p> <ul style="list-style-type: none"> Corrected grammatic errors and formatting throughout the section. Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section.
20250401.14	206-221	<p>XV. Appeals and Grievances</p> <ul style="list-style-type: none"> Corrected grammatic errors and formatting throughout the section. Corrected “BlueCare Plus” to “BlueCare Plus Tennessee” throughout the section. <p>A. Member or Representative Appeals and Grievances</p> <p>2) Appeal Levels</p> <ul style="list-style-type: none"> Corrected the time frame from 60 to 65 days for a reconsideration decision. Appendix 1 graphic updated <p>3) Representatives Filing on Behalf of Members</p> <ul style="list-style-type: none"> Added a bullet point <p>6) Organization Determination</p> <ul style="list-style-type: none"> Updated designated time frames within this section for Part B. <p>9) Re-Opening Time Frames</p> <ul style="list-style-type: none"> Updated the time frame on bullet two to 4 years.

Update 20250101

Correction	Page	Description
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H3259_W14_P2_20260401

20250101.01	Cover	Updated Cover Page/Cover Art
20250101.02	2-15	Updated Table of Contents
20250101.03	16-19	I. Introduction Corrected grammatic errors throughout the section.
20250101.04	20-28	II. Administration Corrected grammatic errors and formatting throughout the section. <ul style="list-style-type: none"> A. General Information <ul style="list-style-type: none"> 1. Interpretation Services <ul style="list-style-type: none"> • Corrected phone number formatting. 3. Important Contact Information <ul style="list-style-type: none"> • Removed: If you are not registered, go to http://www.Availity.com and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard B. Compliance <ul style="list-style-type: none"> 4. Requirements for Reporting Fraud and Abuse <ul style="list-style-type: none"> • Removed: Persons are encouraged to report suspected fraud and abuse. C. Coordination of Benefits , Medicare Secondary Payer and Third party Liability <ul style="list-style-type: none"> • Someone incorrectly added the wording “The provider should,” but it has been removed as clean version did not have it. • Added Wording: The policy# listed on the member’s identification card should be submitted on the EOB. If the correct policy# is not filed, the claim will be denied. A corrected bill will need to be submitted. • Changed the placement of sentence: If BCPTN learns of the availability of primary insurance after it has made payment to the provider, then BCPTN may recover its payment to the provider if all of the following conditions are met. • Specified timeframes were updated: When providers choose to appeal the refund request letter from BCPTN, they are given sixty (60) calendar days in addition to the thirty (30).
20250101.05	29-36	III. Member Enrollment

		<p>Updated grammatic and formatting changes throughout the section.</p> <ul style="list-style-type: none"> • Changed the following sentence to distinguish three products and change the wording: BlueCare Plus Tennessee offers enrollment under two three distinct products: BlueCare Plus (HMO D-SNP) and BlueCare Plus Choice (HMO D-SNP) and BlueCare Plus Select (HMO D-SNP). <p>A. Special Enrollment Period and Disenrollment</p> <ul style="list-style-type: none"> • This entire section was deleted per FPP as it is going away as of 1/1/25. • Changed the year to 2025, changed the OOP Maximum to \$9,350 in the BlueCare Plus Tennessee Benefits Table. <p>B. Member ID Cards</p> <ul style="list-style-type: none"> • Corrected Member ID Cards Inserted
<p>20250101.06</p>	<p>37-77</p>	<p>IV. Provider Requirements</p> <p>Updated grammatic and formatting changes throughout the section.</p> <ul style="list-style-type: none"> • Provider Networks • Network Participation Criteria • Someone changed the numbering beside, “Hospital Based” to a “B.” Changed it back to a “2.” • Changed the wording in two bullets to make it just one bullet: Initiating legal or administrative actions against BCBST/BCPTN in bad faith; BCBST's/BCPTN's pending or termination of the provider's participation agreement for cause; Prior or pending collection actions against members in violation of an applicable hold harmless requirement. <p>4. Removal of Providers from BCBST/BCPTN Provider Network</p> <ul style="list-style-type: none"> • Changed the wording in the bullet: Debarred or suspended by the Federal Employee Program/Postal Service Health Benefits Office of Personal Management (OPM) <p>C. Credentialing Policies</p> <ul style="list-style-type: none"> • Under “Acupuncturist” updated bullet to read: A Drug Enforcement Administration (DEA) certificate isn’t required. • Under “Addiction Medicine Addictionologist (Buprenorphine – based therapy for medication assisted treatment of substance use disorder)” updated a bullet to say:

		<p>Certified in buprenorphine therapy in the state where practice is to occur.</p> <ul style="list-style-type: none"> • Under Chiropractor updated a bullet to only say: Certified in buprenorphine therapy in the state where practice is to occur. • Under Certified Registered Nurse Anesthetist (CRNA) updated a bullet to only say: A DEA certificate isn't required. • Under Dentist-General, updated a bullet to only say: A DEA certificate isn't required. • Under Dentist-Orthodontics, updated a bullet to only say: A DEA certificate isn't required. • Under Dentist-Pediatric Dentistry, updated a bullet to only say: A DEA certificate isn't required. • Under Dentist-Lactation Specialist, updated a bullet to only say: A DEA certificate isn't required. • Under Neuropsychologist (Ph. D), updated a bullet to only say: A DEA certificate isn't required. • Under Nurse Practitioners or Nurse Mid-Wife, updated a bullet to only say: A DEA certificate isn't required. • Under Nurse Practitioner – Master's Clinical Nurse Specialist/Psychiatric Nurse, updated a bullet to only say: A DEA certificate isn't required. • Added a new section: Nurse Practitioner – Working at an On-Site Clinic (Premise, Sanitas, McKee, etc) • Under Nurse Practitioner – Working in a Pain Management Setting, updated a bullet to only say: A DEA certificate isn't required. • Under Nurse Practitioner – Working in the Urgent Care Setting added a bullet to read: Hospital privileges aren't required. Corrected an additional bullet to only read Call coverage isn't required. • Changed a subsection heading to read: On-Site Clinic Providers – MD and (DO's (Primary Care) – (Example – Premise Health, Sanitas, McKee, etc.) • Under On-Site Clinic Providers – MD and (DO's (Primary Care) – (Example – Premise Health, Sanitas, McKee, etc.) changed a bullet to read: A DEA certificate is required. • Under On-Site Clinic Providers – MD and (DO's (Primary Care) – (Example – Premise Health, Sanitas, McKee, etc.) changed a bullet to read: Call coverage isn't required. Site visit provider is a PCP.
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		<ul style="list-style-type: none"> • Changed a subsection heading to read: On-Site Clinic Providers – MD and DO’s (Specialist) – (Example – Premise Health, Sanitas, McKee, etc.) • Under On-Site Clinic Providers – MD and DO’s (Specialist) – (Example – Premise Health, Sanitas, McKee, etc.) added a bullet stating: A DEA certificate is required. • Under Optometrist changed a bullet to read: A DEA certificate isn’t required. • Under Pathologist changed a bullet to read: A DEA certificate isn’t required. • Under Pharmacist- Clinical removed the bullet: Collaborative Practice agreement between the pharmacist and physician. • Under Pharmacist - Clinical changed a bullet to read: A DEA certificate isn’t required. • Under Pharmacist – Disease Management / Pharmacotherapy: changed a bullet to read: A DEA certificate isn’t required. • Under Pharmacist – Immunizing: changed a bullet to read: A DEA certificate isn’t required. • Under Physician Assistant: changed a bullet to read: A DEA certificate isn’t required. • Added a new section: Physician Assistant – Working in an Onsite Clinic (Premise, Sanitas, McKee, etc) • Under Physician Assistant - Surgical Assist: (Specialist) added a bullet reading: The name and address of the supervising physician – (must be credentialed and/or contracted with BCBST). • Under Physician Assistant - Surgical Assist: (Specialist) deleted a bullet reading: License verifies education. • Under Physician Assistant - Surgical Assist: (Specialist) deleted a bullet reading: Supervising physician must be credentialed and/or contracted with BCBST. • Under Physician Assistant - Surgical Assist: (Specialist) corrected a bullet to read: A DEA certificate isn’t required. • Under Physician Assistant - Working the Urgent Care Setting: corrected a bullet to read: Hospital privileges aren’t required. • Under Physician Assistant - Working the Urgent Care Setting: corrected a bullet to read: Call coverage isn’t required. • Under Physician Assistant - Working the Urgent Care Setting: added a bullet reading: A DEA certificate is required.
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		<ul style="list-style-type: none">• Under Podiatrist corrected a bullet to read: Hospital privileges aren't required.• Under Podiatrist corrected a bullet to read: Call coverage is required - Must be another practitioner in a like specialty (must be credentialed and/or contracted with BCBST)• Under Professional Counselors corrected a bullet to read: A DEA certificate isn't required.• Under Psychologists, Clinical or Clinical Child & Adolescent Psychologists (includes Psychologist and Psychoanalyst) corrected a bullet to read: A DEA certificate isn't required.• Under Psychologists, Clinical or Clinical Child & Adolescent Psychologists (includes Psychologist and Psychoanalyst) corrected a bullet to read: 24/7 call coverage or arrangements – Answering machine/cell phone is acceptable.• Under Radiologist Diagnostic corrected a bullet to read: A DEA certificate isn't required.• Added a new subsection: <u>Urgent Care Providers - MD and DO's - (Primary Care and Specialist)</u> <p>1. Credentialing Process for Medical and Behavioral Health Organizational Providers</p> <ul style="list-style-type: none">• Under Ambulatory Surgical Facility - (Primary Care and Specialist) removed a bullet reading: Medical Director credentialed by BlueCross.• Under Dialysis Facility added a bullet to read: Other States: Licensed in accordance with the states licensing laws.• Under Home Infusion Therapy Providers corrected a bullet to state: Accreditation isn't required.• Under Home Health Agency corrected a bullet to state: Accreditation isn't required.• Under Hospice Provider corrected a bullet to state: Accreditation isn't required.• Under Independent Lab corrected a bullet to state: Accreditation isn't required.• Under Intensive Outpatient (Substance Abuse Disorder) added a bullet to read: General liability insurance isn't required.• Under Non-Licensed DME Providers (Non-motorized equipment only e.g., walker canes, crutches) removed two bullets.
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		<ul style="list-style-type: none"> • Under Orthotic/Prosthetic Supplier one bullet point removed. • Under Opioid Treatment Program changed language on bullet point. • Under Outpatient Mental Health Facility changed verbiage on multiple bullets and removed a complete bullet. • Under Outpatient Substance Abuse Disorder Clinic changed verbiage on multiple bullets and removed one full bullet. • Under Outpatient Rehabilitation Facility removed one full bullet. • Under Pain Management Center changed verbiage on one bullet. • Under Partial Hospitalization (Psychiatric or Substance Use Disorder) changed verbiage on multiple bullets. • Under Professional Support Services Licensure (PSSL) changed verbiage on one bullet. • Added a new sub section: Psychiatric Hospital • Under Psychosocial Rehabilitation Center verbiage change on one bullet. • Under Rural Health Clinics verbiage change on multiple bullets. • Under Skilled Nursing Facility (No Swing Beds) changed verbiage on one bullet. • Under Urgent Care Centers changed verbiage on one bullet. <p>3. Approved Specialties</p> <ul style="list-style-type: none"> • Under American Board of Medical Specialties (ABMS) added and removed multiple categories from I. - XXIV
20250101.07	99-114	<p>V. General Guidelines for Benefits</p> <p>Several grammatic and formatting errors corrected.</p> <p>C. Chiropractic Services</p> <ul style="list-style-type: none"> • Corrected grammar in one sentence of this section. <p>I. Behavioral Health Services</p> <p>4. Prior Authorization</p> <ul style="list-style-type: none"> ○ Phone Numbers Validated <p>8. Treatment Record Requirements</p> <ul style="list-style-type: none"> ○ Links Validated. <p>9. Contact Us</p>

		<ul style="list-style-type: none"> ○ Links and Phone Numbers Validated <p>J. Dental</p> <ul style="list-style-type: none"> • Corrected the year to 2025. • Verbiage correction to paragraph three. • Verbiage correction under Comprehensive Services. <p>L. Preventative Services</p> <ul style="list-style-type: none"> • Age correction under colorectal screening. <p>M. Hearing Services</p> <ul style="list-style-type: none"> • Effective date changed to 1/1/2025. • Grammar change to last sentence. <p>N. Over the Counter (OTC)</p> <ul style="list-style-type: none"> • Dollar coverage amount corrected. • Verbiage changes throughout the section. <p>R. Transportation</p> <ul style="list-style-type: none"> • Slight verbiage/clarification changes in this section. <p>S. Vision Services</p> <ul style="list-style-type: none"> • Verbiage changes and adding annual coverage limit dollar amount of \$500.
20250101.08	118	<p>VII. Pharmacy</p> <ul style="list-style-type: none"> • Corrected hyperlink.
20250101.09	121-127	<p>VIII. Model of Care (MOC) D-SNP</p> <p>A. SNP target Population</p> <ul style="list-style-type: none"> • Removed, “a new plan effective 1/1/23” from verbiage. <p>B. Model of Care Overview</p> <ul style="list-style-type: none"> • Grammatic changes to the second to last bullet point. Also, changed the minimum from monthly to annually. <p>C. Staff Structure and Care Management Roles</p> <ul style="list-style-type: none"> • Slight grammatic change in the second to last paragraph. <p>E. New Provider Orientation and Training</p>

		<ul style="list-style-type: none"> Added a sentence to the second to last paragraph. Slight grammatic change to the last paragraph. <p>F. Provider Education and Ongoing Training</p> <ul style="list-style-type: none"> Slight grammatic change to the second paragraph. <p>H. Individualized Care Plan</p> <ul style="list-style-type: none"> Slight grammatic change to the second to last paragraph. <p>M. Model of Care Process Summary</p> <ul style="list-style-type: none"> Removed, “a new plan effective 1/1/23” from the first paragraph.
20250101.10	129	<p>IX. Care Management</p> <p>A. Referrals and Triage</p> <ul style="list-style-type: none"> Removed a sentence from this section.
20250101.11	134-156	<p>X. Utilization Management</p> <p>A. Utilization Management Guidelines</p> <ul style="list-style-type: none"> Updated released date to July 2024. <p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> Slight punctuation change. Added a bullet under: Information that needs to be submitted with the claim and/or prior authorization (when applicable) request: Added a sentence under: Investigational Services to state: If the FDA or CMS initially approves a procedure, device, or medication, it might still be considered experimental if there isn’t enough peer-reviewed research proving it’s safe and effective compared to existing treatments. Also, slight grammar changes in the last paragraph. <p>L. Provider Appeals</p> <p>Slight grammatic and punctuation changes throughout the section.</p> <ul style="list-style-type: none"> Time frame changed from 3 to 2 times. Verbiage changes throughout paragraph two. <p>M. Reopening</p> <ul style="list-style-type: none"> Slight grammatic change in the second paragraph.

20250101.12	169	<p>XII. Billing and Reimbursement</p> <p>9. Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)</p> <ul style="list-style-type: none"> Under Block 24b – Place of Service on the second paragraph verbiage changes and removing an effective date of 9/1/18.
20250101.13	205-207	<p>XIII. Remittance Advice</p> <ul style="list-style-type: none"> In the second table beside Serv Prov added National Provider Identification Number In the second table beside Procedure/Modifier slight verbiage change. In the third table beside Note added Remark Code. In the third table beside Contract Write Off added Provider Write Off Amount. In the third table beside Claim Paid slight verbiage change. In the third table added a row for Paid. Removed a sentence under the remittance advice example.
20250101.14	212	<p>XIV. Risk Adjustment</p> <p>6. Risk Adjustment Data</p> <ul style="list-style-type: none"> Removed a sentence under the Provider Assessment Forms sub section in the first paragraph. Phone number corrected to 423-591-9504
20250101.15	229	<p>XV. Appeals and Grievances</p> <p>C. BlueCare Plus Choice Reportable Event Management</p> <ul style="list-style-type: none"> Removed the web address at the end of the section and added a hyperlink.

Update 20241001

Correction	Page	Description
20241001.01	Cover	Updated Cover Page/Cover Art
20241001.02	2-8	Updated Table of Contents
20241001.03	30	<p>IV. Provider Requirements</p> <p>A. Provider Networks</p> <p>1. Network Participation Criteria</p> <ul style="list-style-type: none"> IX. Medical – Regular: 1. – Updated language in 1st bullet.

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	33	<ul style="list-style-type: none"> Added Note at end of this section for Individual providers participation in all networks and exception clarification.
	35	<p>3. Providers Denied Participation</p> <ul style="list-style-type: none"> Removed “(1)” from language.
	43	<p>B. Provider Credentialing</p> <ul style="list-style-type: none"> Updated language to be consistent with NCQA terminology in using practitioner vs. provider. EFT – Removed Enrollment reference to CAQH website and link from 1st paragraph.
	43	<p>C. Credentialing Policies - Credentialing Process for Practitioner (Medical and Behavioral Health)</p> <ul style="list-style-type: none"> Updated list as needed for “Specific requirements for specialties”. Updated language to be consistent with NCQA terminology in using practitioner vs. provider, as applicable
	44-55	
	44-55	<p>C.1. – Credentialing Process for Medical and Behavioral Health Organizational Providers</p> <ul style="list-style-type: none"> Updated special requirements list, as needed.
	55-61	
	61	<p>C.3. – Approved Specialties</p> <ul style="list-style-type: none"> Updated language to be consistent with NCQA terminology in using practitioner vs. provider, as applicable. Updated list for ABMS - V. added H
	62	
	74	<p>C.4. – Accrediting Bodies We Recognize</p> <ul style="list-style-type: none"> Updated “ABC” to “ABCOP”, Added “ASAM” back, updated “BOC” acronym, added “Pediatric Nursing Certification Board”.
20241001.04	93	<p>V. General Guidelines for Benefits</p> <p>I. Behavioral Health Services</p> <ul style="list-style-type: none"> 4. Prior Authorization - Updated bullet #3 language, added “Intensive Outpatient Program” bullet, and removed ECT and Psych/NeuroPsych bullets because testing no longer requires PA.
20241001.05	125	<p>X. Utilization Management</p> <p>D. Prior Authorization</p> <ul style="list-style-type: none"> Removed ECT and Psych/NeuroPsych bullets because testing no longer requires PA t.
	127	<p>E. Prior Authorization Review</p> <ul style="list-style-type: none"> In 6th paragraph, updated language.
	130	<ul style="list-style-type: none"> a. ii. Lifetime Reserve Days – Added clarification language to end paragraph.
	130	<ul style="list-style-type: none"> b. Added bullet/language for PASRR payment requirement

	137 141-142 145	<ul style="list-style-type: none"> c. Added Home Health Services language. <p>G. CMS Guidance for Outreach to Support Coverage Decisions</p> <ul style="list-style-type: none"> Updated 1st bullet language to combine 1st and 2nd bullet language. Removed 2nd bullet. <p>L. Provider Appeal</p> <ul style="list-style-type: none"> Inpatient DRG Extension – Added language to end of 1st paragraph.
20241001.06	155	<p>XII. Billing and Reimbursement</p> <p>A. Claims Processing</p> <ul style="list-style-type: none"> 6. Corrected Bills – Added language to end of 1st paragraph for electronic and paper corrected claims that don't follow billing guidelines.
20241001.07	219	<p>XV. Appeals and Grievances</p> <p>C. BlueCare Plus Choice Reportable Event Management</p> <ul style="list-style-type: none"> Effective 7/1/24, DIDD is now The Department of Disability and Aging (DDA), changed language to reflect change.

Update 20240701

Correction	Page	Description
20240701.00	Cover	Updated Cover Page/Cover Art
20240701.01	Various	Reformatted as needed, throughout document.
20240701.02	2-8	Updated Table of Contents
20240701.03	20	II. Administrative, C. 9th paragraph, 2nd bullet – Replaced “BlueCare Plus” with “BCPTN”
20240701.04	23	III. Member Enrollment, B. - Added “MCO” to 2nd line language
20240701.05	42-43 43-53 58 59-71 72	<p>IV. Provider Requirements</p> <p>B. 2. – Formatting edit (made existing language a bullet point)</p> <p>C. Credentialing Policies - Credentialing Process for Practitioner (Medical and Behavioral Health) - Updated list as needed for “Specific requirements for specialties”.</p> <p>C.1. – Updated last bullet language under “Sleep Labs”.</p> <p>C.3. – Updated lists for ABMS, AOA.</p> <p>C.4. – Removed “ASAM” from list of Accrediting Bodies We Recognize.</p>

20240701.06	86	V. General Guidelines for Benefits B.1. Continuous Glucose Monitors Covered Under Part B – Updated - Language in 1st paragraph for PA and supplies limitations.
20240701.07	124 125 127-128 136 140	X. Utilization Management D. Updated 7th bullet and added bullet to end of list. E. In 8th paragraph, updated 3 days to 7 days. Readmission Quality Program (i) – Updated language in 4th bullet. (ii) – Durable Medical Equipment – Added language to end of the 1st bullet for compliance report requirement. F. UM Contact Info – Updated link to Fax forms
20240701.08	158 164 185 192	XII. Billing and Reimbursement A.9.Block 24b-Place of Service: Added language with POS codes for possible member residence. B.1. Added language for professional claims/taxonomy codes. D.12. Added “Plus” to clarify reference to BlueCare Plus Tennessee in 6th paragraph (before the grid) E. General Billing and Reimbursement Information – Within the grid, updated hyperlinks for Hospice, Part B Drugs, and Anesthesia providers.
20240701.09	195 196	XIII. Remittance Advice Within the grid, payment information – updated language for Patient DED/COPAY, and Patient COINS. Under the example of BCPTN Remittance Advice copy, 1st paragraph – updated language by adding “member’s assigned TennCare MCO” and removing “ Division of TennCare”.
20240701.10	202	XIV. Risk Adjustment 6. Risk Adjustment Data, Provider Assessment Forms – 2nd paragraph: Added “or 96161” to language.
20240701.11	204-205	XV. Appeals and Grievance A.1.Definition of Terms, Cost Sharing Obligations – Added clarifying language in regards to MCO.

Update 20240401

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Correction	Page	Description
20240401.01	3	Table of Contents updated- Added #8 Provider Identification Number Process and updated numbering sequence for 9 and 10.
20240401.02	31-38	<p>Chapter IV. Title A.1</p> <p>Add paragraph language-</p> <p>Our network participation criteria is governed by the Provider Participation Status Committee (PPSC), which evaluates and oversees Provider participation and takes appropriate actions that aren't quality of care issues. Quality of Care issues are governed by the Clinical Risk Management Committee and the Credentialing Committee.</p> <p>Updated for and added/updated/deleted language for I. and II.</p> <p>Multiple updates from upper to lower case grammatical changes for "Provider" to "provider" and "Member" to "member"</p> <p>#4. Deleted "Except as set forth in Section XI. Quality Improvement Program of this Manual, the" and added language- "The provider Participation Status Committee". Updated language in the 2nd and 3rd paragraphs also. Deleted the number sequence.</p> <p>Added new language and bullet "Deactivated NPI or no NPI"</p>
20240401.03	40-43	<p>Chapter IV. Title A.6. Federal Exclusions Screening Requirements</p> <p>2nd bullet added the following language- "(as of the date such Exclusion Lists are accessed by the provider" and language "and registry checks"</p> <p>Deleted "the" Updated has to Has for proper Upper case grammatical</p> <p>Updated "their" to "provider's", deleted "as such"</p> <p>Deleted "to BCBST/BCPTN" and "or has become", "Medicare and Medicaid", "BCBST"</p> <p>Replaced "with the Provider" with "with them"</p>
20240401.04	45	<p>Chapter IV. Title B.1. Introduction</p> <p>B.2. Credentialing Application- deleted extra bullet to correct format issue.</p>
20240401.05	46	Added C. Credentialing Policies Title-updated format for outline due to added Title.

20240401.06	46	Credentialing Process for Practitioner: 4 th bullet- deleted 90 days and added 6 months language.
20240401.07	48-57	<p>Chapter IV. Title C. Credentialing Policies</p> <p>Addictionologist, Anesthesiologist and Audiologist had language updated. Addictionologist first bullet removed “Must Be” language.</p> <p>Anesthesiologist added “Licensed as a MD or DO” and added the following language on the last bullet “Must be a practitioner in a like specialty (must be credentialed and/or contracted with BCBST). Updated format font to bold for “licensed” bullets for specialties.</p> <p>Dentist section- 3rd bullet- Added language (Must be credentialed and/or contracted with BCBST).</p> <p>Dermatology section- “(Specialist)” language was deleted.</p> <p>Hospice & Palliative Care Practitioner- 5th bullet added language “Clinical privileges aren’t required”.</p> <p>Marriage and Family Therapist deleted 2nd bullet and all language associated, added new bullet with language “Admitting privileges aren’t required”.</p> <p>Neuropsychologist (Ph.D) had language “Admitting privileges not” deleted.</p> <p>Nurse Practitioner-Masters Clinical Nurse Specialist - language “can” deleted and “Must” added.</p> <p>Nurse Practitioner-Working in a Pain Management Setting had language “(Specialist)” deleted. Bullet and language deleted- “The name and address of the supervision practitioner, (must be credentialed and/or contracted with BCBST).</p> <p>Obstetrics & Gynecology language updates- 3rd bullet language added- “(must be credentialed and/or contracted with BCBST)” and 4th bullet language added- “Must be a practitioner in a like specialty (must be credentialed and/or contracted with BCBST)”</p> <p>Ophthalmologist (Specialist)- language “(Specialist) deleted, language added to 4th bullet- “Must be a practitioner in a like specialty (must be credentialed and/or contracted with BCBST)”</p> <p>Pain Management (Specialist)- “(Specialist)” language deleted. 3rd bullet- language “required” added to DEA certificate.</p>

		<p>Pharmacist- Disease Management/Pharmacotherapy: “Pharmacotherapy” language added.</p> <p>Physical Therapist/Occupations Therapist/Speech Therapist- multiple language updates:</p> <p>Added and updated bullets to the following for specialty.</p> <ul style="list-style-type: none"> ➤ Licensed as a Physical Therapist ➤ DEA certificate not required ➤ Call coverage not required ➤ Clinical privileges not required <p>Deleted all other bullets.</p> <p>Physician Assistant- deleted 3rd bullet and all language- “If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.”</p>
20240401.08	59	<p>Chapter IV. Title C</p> <p>Radiologist Diagnostic- added language “Diagnostic”</p>
20240401.09	60	<p>Chapter IV. Title C.1.</p> <p>Updated outline format from 3 to 1.</p>
20240401.10	63	<p>Chapter IV. Title C.1.</p> <p>Independent Lab- added language to 1st bullet- “Labs located in a physician office, hospital etc. are exempt from licensure requirements”</p>
20240401.11	64-66	<p>Chapter IV. Title C.1.</p> <p>Intensive Outpatient (Psychiatric) Deleted 5th bullet and all language- “Must have a staff roster of all licensed behavioral health staff members”</p> <p>Intensive Outpatient (Substance Abuse Disorder)- Deleted 4th bullet and language “Must have a staff roster of all licensed behavioral health staff members”</p> <p>Added language for On-Site Clinics</p> <ul style="list-style-type: none"> ➤ State Business License ➤ Oversight by a Medical Director that is currently credentialed by BlueCross ➤ Accreditation by Urgent Care Association of America (UCAOA), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required ➤ Outpatient Substance Abuse Disorder Clinic- deleted 6th bullet and language- “Must have a staff roster of licensed behavioral health professionals”

20240401.12	68	Chapter IV. Title C.2. Skilled Nursing Facility (No Swing Beds) added additional language on last bullet- “if not accredited, must have a copy of the state or CMS site audit”
20240401.13	84	Chapter IV. Title C.4. #10. Replaced “older” with “over” language. #20. Replaced “our” with “the” language
20240401.14	99	Chapter V. Title I.3. Added a new service “Intensive Outpatient Programs” and updated Service Partial Hospitalization (substance abuse) to substance “use”, added *** symbols. Added new language after services listing-).***Effective 1/1/24 dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who receive Medicaid coverage of services furnished by MFTs or MHCs, or IOP services furnished by hospital outpatient departments, community mental health centers (CMHC), rural health clinics (RHC), federally qualified health centers (FQHC), or opioid treatment programs (OTP), Medicare will become the primary payer for these services provided by Medicare-enrolled practitioners or providers.
20240401.15	102	Chapter V. Title I.8. Updated Note information and deleted previous paragraph. NOTE: Behavioral Health practitioner disciplines currently recognized for all Medicare programs and eligible for participation in BCPTN are limited to include physicians, advanced practice nurses, psychologists, and social workers. Effective 1/1/24 LPCs (Licensed Professional Counselors) and LMFTs (Licensed Marriage and Family Therapists) are eligible to apply.”
20240401.16	106	Chapter V. Title I. #8. Treatment Record Requirements- Updated language “Behavioral Health Quality Management” to “BlueCare Tennessee”
20240401.17	206	Chapter XII. Title D.12. Added Revenue Code A9272
20240401.18	209	Chapter XII. Title E. Deleted 2 nd paragraph information for BCBST Lab Testing CR Policy language

Update 20240101

Correction	Page	Description
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20240101.01	3	Table Of Contents #8 Deleted
20240101.02	21	Updated language
20240101.03	24-25	III. Member Enrollment B. Summary of Benefits Format changes: Added language- "The member's assigned", "MCO" and "copayments" Added website link language
20240101.04	31-38	<p>Section IV. Provider Requirements- A. Provider Networks- 1. Network Participation Criteria- updated language to should review the contact list located at https://provider.bcbst.com/contact-us/my-contact and contact and deleted "may call"</p> <p>Added paragraph- If you or your patients may submit a claim to us but you aren't currently interested in network participation, we recommend you register with us by filling out an Out of Network Provider Form located in Availability in the BCBST Payer Space. The purpose of registering with us is to identify key information about you and ensure accurate distribution of payments, remittance advices (Explanation of Payments), and 1099 forms. This registration in no way signifies that you participate in any of our networks.</p> <p>Section 1- added- "as defined in the applicable provider network participation agreement with the Plan</p> <p>Added language- Provider must have a physical location or be employed by a group practice that has a physical location in Tennessee or Catoosa, DeKalb or Walker counties in GA to and deleted language- Contiguous, County to Tennessee or an Overlapping Service Area (Effective DOS Nov. 1, 2022).</p> <p>Added language under IX.-</p> <p>Routine exam, preventive care, physical exam:</p> <p>Adult: Annual, within a year of the last scheduled physical after coverage becomes effective or if the last physical is greater than one year, within three months. For routine care not to exceed 3 weeks from date of a member's request for regular appointment.</p> <p>Children: According to the American Academy of Pediatrics periodicity schedule.</p> <p>Prenatal care: To be seen in the first trimester less than six weeks of patient's suspected pregnancy. If the first appointment is beyond the first trimester less than 15 days</p>

		<p>Deleted language- routine Examination, Preventive Care, Physical Exam, within 3 weeks, 2. 2nd Trimester Prenatal and Withing 15 days.</p> <p>Updated chronological order of IX Section due to additions and deletions.</p> <p>Section 8, 4th bullet- deleted language paragraph.</p> <p>Section 10- deleted language Process and added Procedure</p> <p>Section 12-added language- may include Catoosa, Date and Walker Counties in Georgia.</p> <p>Section 13- Deleted language- As example- language- may.</p> <p>Updated grammatical and format for section.</p> <p>Section 14. deleted “upon care” and added “when” and “is resolved”</p> <ul style="list-style-type: none"> ➤ Updated III section- Added language “not meeting any of these criteria”, and unless otherwise specified in the termination notice, the”, “failed requirement” “in the event of an arrest” and “may” ➤ Deleted language “and unless otherwise specified in the termination notice, the” ➤ Section 2-Changes in Practice added paragraph language-We require individual practitioners to update and/or attest to their information in CAQH within 90 days of the notification to validate their data information. For facilities and ancillary providers, we require the return of every data verification form (DVF) received (even if there are no updates) every quarter. Depending on specialty and practice location, some providers may receive multiple attestation requests; providers must attest to each request for verification they receive. If an attestation isn’t made in CAQH within a timely manner or if a DVF isn’t signed, dated, and returned every quarter, the provider may be removed from our provider directory until they update and/or attest that their information is accurate. Removal from the directory won’t impact network participation or claim processing. Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure provider directories used by members contain the most current and correct information about your practice. Deleted language- “Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure Provider directories utilized by Members contain the most current and correct information about their practice.
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		<ul style="list-style-type: none"> ➤ Added language- “changes” and “Changes in tax or group NPI”, “A particular practitioner” and “Changes to” and deleted language- “set forth”, “Entering into or exiting from a group practice,” ➤ Added language-“Institutions, Ancillary Providers, and group practices must timely report to us any changes to their practice,” and “or control, including a change to or addition of a tax identification number or NPI” ➤ Deleted language- “Adverse or a” and added “A” ➤ Section 4. Removal of Provider from BCBST/BCPTN ➤ Deleted language- “State” and added “BCBST/BCPTN exclusive service area” ➤ Added language- “Lack of valid NPI” and “If” and “on “and deleted- “In those cases where”
<p>20240101.05</p>	<p>40-43</p>	<ul style="list-style-type: none"> ➤ IV. Provider Requirements- A. Provider Networks- 6. Federal Exclusions Screening Requirements Section ➤ Updated language- Added- “The following definition apply and deleted-“the following definitions shall apply” ➤ Added language “Exclusion Lists”, deleted ““Exclusion Lists”, “means the”, “For Subcontractors, in addition to the forgoing, the definition of “Exclusion Lists” also includes”. ➤ Deleted language- “as of the date such Exclusion Lists are accessed by the Provider,” and deleted “(b)” ➤ Updated grammatical and format. ➤ Added language- “(making them)”, “They also need to conduct criminal background checks in accordance with state law” and “At a minimum, registry and exclusion checks must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, TennCare Terminated Provider List and the Social Security Death Master File.” ➤ Deleted language-“,whether contract or non-contract,” and added language, “their”. Deleted language “as a result of the”, “shall” “such”, “shall” ➤ Updated additional language and format. ➤ Added language- “precluded or debarred” ➤ Added language- “If BCBST/BCPTN discover a practitioner that is part of a group practice is excluded, precluded, or debarred, BCBST/BCPTN will remove that practitioner from all BCBST Medicare and Medicaid participating networks in accordance with the administrative termination provisions in Section 4. BCBST/BCPTN will also recover any claims reimbursed for dates of service after the exclusion effective date.

		<ul style="list-style-type: none"> ➤ Deleted language- "in order for the claims recovery period to be adjusted" ➤ Section 7. Subcontracting. Deleted #8 and updated format.
20240101.06	45	Updated language to delete address information verbiage.
20240101.07	46	Added language-(must be credentialed and/or contracted with BCBST)
20240101.08	48-71	IV. Provider Requirements B.2 Credentialing Application Multiple language changes per new credentialing process updates.
20240101.09	84-85, 88	IV. Provider Requirements B.6. Accrediting Bodies We Recognize Updated format to underline Practice Site Standards. Added language "approximately" and updated format. Updated language for #19.
20240101.10	93	V. General Guidelines for Benefits B. Services, Supplies and Durable Medical Equipment 1. Medical Equipment. Added language- "some" "and" and Deleted language- "-G6", "Libre 14-day and Libre"
20240101.11	101	V. General Guidelines for Benefits D. Part B Drugs Updated language
20240101.12	107, 110	V.I.8. Treatment Record Requirements. Added link to language
20240101.13	110	V. General Guidelines for Benefits R. Transportation Updated format to 10 point Font
20240101.14	123, 140	VIII. Model of Care (MOC) D-SNP B. Model of Care Overview Added language- "(Medicaid Benefit)"
20240101.15	133	X. Utilization Management Guidelines A. Utilization Management Guidelines
20240101.16	140	Updated to Bold Font Format
20240101.17	144	X. Utilization Management E. Prior Authorization Review-Readmission Quality Program. Updated language
20240101.18	145	Updated format to 10 pt Font
20240101.19	147	Added language- DME specified per CMS to be rental items will not be approved for purchase except in rare circumstances.

20240101.20	151	X. Utilization Management E1. Readmission Quality Program Updated & Deleted language
20240101.21	156-157	X. UM F. UM Contact Information Added language “(TennCare reporting)” Updated language
20240101.22	209	XII-D12. National Drug Code (NDC) Billing Added language “(TennCare reporting)”
20240101.23	210	XII. Billing and Reimbursement D.12 National Drug Code(NDC) Billing Updated codes in charts.
20240101.24	213-214	XII. Billing and Reimbursement E. General Billing and Reimbursement Information-Added new language: NOTE: BCPTN uses the following hierarchy for coding, billing, and reimbursement of claims. Provider’s contract BCBST policies and procedures CMS guidelines Coding guidelines from CPT Coding guidelines from coding organizations
20240101.25	219	Updated language
20240101.26	224	Added language- “Office of Medicare Hearings and Appeals
20240101.27	228	Updated bold font format
20240101.28	231	Added bullet to format and updated language; deleted “a clerical” and added “not an”
20240101.29	232	Added new paragraph with language- **NOTE: If the service/item has not been provided to a member and the provider wishes to appeal a denial, the member appeals process as noted above is to be used for timely filing and processing.
20240101.30	239	XIV. Appeals and Grievances C. BlueCare Plus Choice Reportable Event Manager- added language paragraph-For any Reportable Event, the provider shall have supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Reportable Behavioral Events, this may include follow up with the member’s PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the person’s Care Coordinator, Support Coordinator, Independent Support Coordinator, or DIDD Case Manager regarding any needed adjustments in the Person Centered Support Plan, and targeted training or assistance for agency staff who support the person. All Reportable Events, any medical attention provided, and follow up shall be documented in the member’s record.

Update 20231001

Correction	Page	Description
20231001.01	47-58 59-67 80-84	<p>IV. Provider Requirements</p> <ul style="list-style-type: none"> ➤ B. 2. Updated list as needed for “Specific requirements for specialties”. ➤ B.3. Updated list for medical and behavioral health organizational providers and their requirements, as needed. ➤ B.6. Added new section and language “Practice Site/Medical Record Standards”
20231001.02	91 94 99 100 102 104	<p>V. General Guidelines for Benefits</p> <ul style="list-style-type: none"> ➤ In last paragraph (before section A.), changed “BCPTN” to “BlueCare Plus” ➤ B.1. Added language “Reasonable useful lifetime restrictions apply” to end of 2nd sentence under “replacement”. ➤ I.4. Updated language for authorization requests within 5th and 6th paragraphs. ➤ I.6. Updated email hyperlink for Provider Support. ➤ I.8 Under Consent Forms Signed by Member/Parent/Guardian: Removed hyperlinks for tnsosfiles and mcgmilliman. Added MCG Cite Guidelines hyperlink. ➤ I.8. Complaints and Quality of Care Concerns: Removed language at end of paragraph regarding investigation of all reports complaints by BHQM.
20231001.03	113	<p>VI. Non-Covered Benefits</p> <ul style="list-style-type: none"> ➤ A. In the Note at the end of the section, changed “BCPTN” Choice to “BlueCare Plus” Choice.
20231001.04	133 135 136 140 145 149-150	<p>X. Utilization Management</p> <ul style="list-style-type: none"> ➤ A. Added Note with MCG used as a guide language, and changed “BCPTN” to “BlueCare Plus”. ➤ D. Updated and added language to the bulleted list of PA requirements for coverage and medical necessity for BCPTN members. ➤ E. Added language to 5th and 8th paragraph. ➤ E. Lifetime Reserve Days – SNF: Added language to 1st paragraph. ➤ E. Observation Stays: added COPD exacerbation language to 2nd paragraph. ➤ E. Added title and language for “Clinical Trials” ➤ K.C. Added language at the end of the 1st paragraph.

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	154 155- 156	<ul style="list-style-type: none"> ➤ L. Added language to 2nd paragraph under “Peer-to-Peer RE-Evaluation Processes”, deleted “appeal” within 5th paragraph, replaced “organization determination” with “appeal” within the 6th paragraph, and added POA language within 8th paragraph.
20231001.05	193	<p>XII. Billing and Reimbursement</p> <ul style="list-style-type: none"> ➤ D6.(i). Added and updated language to 4th and last bullet.
20231001.06	218 220- 222 223 224 230 234	<p>XIV. Appeals and Grievances</p> <ul style="list-style-type: none"> ➤ A. Updated language to end of the 1st paragraph. ➤ A. 1. Removed some of the “Definition of Terms” from list. ➤ A.2. Level 1 Appeal: Added “or treating physician” to 1st bullet ➤ A.2. Level 2 Appeal: Added “(fully or partially)” to 2nd bullet. ➤ A.7. Added “(WOL)” to language. ➤ C. REM Requirements: Added language with hyperlink

Update 20230701

Correction	Page	Description
20230701.01	Various 29-32 32-34 36-54 54 54 56- 73,83- 84	<p>IV. Provider Requirements :</p> <ul style="list-style-type: none"> ➤ Re-formatted language, where needed. ➤ A.1.– Added criteria language, and re-formatted as needed. ➤ A.2., A.4, – Updated language and bullets. ➤ A.6 – Removed entire “Participation in BCPTN Networks” section and replaced with “Federal Exclusions Screening Requirements” ➤ A.7 – Added “Subcontracting” title and language ➤ A.9 – Added “ Interoperability Standards and HITECH Act” section and language. ➤ B. 1, B.2.– Updated language, and added edits to adhere to BCBST Brand Voice standards which are non-material.
20230701.02	97 106	<p>V. General Guidelines for Benefits:</p> <ul style="list-style-type: none"> ➤ B. 1. – Updated language under Medical Equipment ➤ I.8. – Updated bullets/language under BH Quality Management

20230701.03	137	X. Utilization Management : ➤ Section E.1.b. - Added language for Lifetime Reserve Days
20230701.04	166-174 188 197 198-202	XII. Billing and Reimbursement: ➤ Section A.9. – Added title and language for DMEPOS. ➤ Section D.1. – Added “procedures” to language. ➤ Section D.12. – Updated “BCBST” to “BCPTN” where applicable. ➤ Section D.15 – Updated the Home Health grid, reformatted the Revenue Code 0270 grid, and updated/added language.

Update 20230401

Correction	Page	Description
20230401.01	14	Added and Updated bullets/language
20230401.02	32	Added bullet/language
20230401.03	57,63	Updated language for Acupuncturist, Physician Assistant-Surgical Assist, Psychologists, Clinical or Psychologist, Clinical Child & Adolescent, Radiologist
20230401.04	64-66, 68-70, 83	Updated bullets/language for minimum criteria required and/or must be verified for Organizational Practitioners:
20230401.05	83	Updated list for BCPTN Recognized Accrediting Bodies
20230401.06	96	Updated language for Medical Equipment
20230401.07	107	Added National Crisis Hotline under Contact Us for BH Services
20230401.08	134,143	Added language under Prior Authorization Review
20230401.09	151	Removed language under Mandated Notice
20230401.10	152	Updated language under Provider Appeal
20230401.11	178	Updated language for Block 23
20230401.12	181	Added language for Block 32
20230401.13	195	Added additional Billing Codes

Update 20230101

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Correction	Page	Description
20230101.00	All	In several places throughout the entire PAM, "BlueCare Plus" updated to "BCPTN" or "BlueCare Plus Tennessee." There are also several formatting changes throughout the PAM in reference to the title of the network(s).
20230101.01	8	Language added
20230101.2	9	Language added
20230101.3	11	Language added
20230101.4	12	Language updated
20230101.5	13	Language added/updated rid
20230101.6	14	Language changed/grid updated
20230101.7	15	Grid updated
20230101.8	22	Language changed
20230101.9	24	Language removed
20230101.10	25	Language changed
20230101.11	28	Language/hyperlink changed
20230101.12	29	Language added
20230101.13	30	Removed form/hyperlink changed
20230101.14	54	Language added
20230101.15	57	Language removed
20230101.16	60	Language removed
20230101.17	63	Language added/removed
20230101.18	65	Removed "restricted trademark" symbols
20230101.19	66	Language removed
20230101.20	68	Language removed from CMHC
20230101.21	69	Removed "or"
20230101.22	70	Added "(TJC)"

20230101.23	82	Added TMQC to list
20230101.24	92	Language added/removed
20230101.25	95	Hyperlink added
20230101.26	97	Language added/removed/hyperlink changed
20230101.27	105	Language removed
20230101.28	106	Dental updated
20230101.29	107	Preventative/Comprehensive services updated
20230101.30	108	Screening for Lung Cancer age changed from 55 to 50
20230101.31	109	Hearing Services updated/"items" added to OTC title
20230101.32	110	Language added to Podiatry, Transportation, & Vision Services
20230101.33	111	Language changed
20230101.34	112	Language removed
20230101.35	114	Formulary links updated from 2022 to 2023
20230101.36	116	Language removed
20230101.37	117	Language updated
20230101.38	118	Language changed
20230101.39	119	Language changed
20230101.40	120	Language updated/Section G updated
20230101.41	121	Language updated
20230101.42	122	Language changed
20230101.43	123	Language updated
20230101.44	124	Language updated
20230101.45	125	Language updated
20230101.46	126	Language updated
20230101.47	127	Language updated

20230101.48	128	Language updated/Maternity Case management section removed
20230101.49	129	Language updated
20230101.50	130	Language added/removed
20230101.51	131	Language updated
20230101.52	133	Language added
20230101.53	134	Language added/Readmission Quality Program language added
20230101.54	136	Language removed
20230101.55	140	Language removed
20230101.56	141	Language added
20230101.57	144	Language added
20230101.58	147	Language changed
20230101.59	148	Language changed
20230101.60	150	Language added
20230101.61	151	Language added
20230101.62	152	Language added
20230101.63	182	Language changed
20230101.64	184	Language added
20230101.65	185	Language added
20230101.66	191	Dialysis Freestanding Facility section added
20230101.67	194	Reimbursement General Provisions section changed
20230101.68	204	Provider Assessment Forms section added/CKD & ESRD Patient Registration section added
20230101.69	208	MA Agreement removed
20230101.70	217	Form removed
20230101.71	222	FIDE removed from title from Section C

Update 20221001

Correction	Page	Description
20221001.01	57	Added "organization providers" to intro
20221001.02	58	Added "organization providers"
20221001.03	59	Added Addictionologist (Non-Psych) and Addictionologist (Buprenorphine)
20221001.04	60	Language added, Behavior Analyst section added
20221001.05	61	Language added, removed Genetic Counselor
20221001.06	62	Language added, LCSW and Marriage & Family Therapist added
20221001.07	63	Language added, Nurse Pac. Clinical Nurse Specialist and Psych. Nurse added
20221001.08	65	Professional Counselors and Psychologists or Psychoanalyst added
20221001.09	66-72	Language added, several new sections added to list
20221001.10	74	Language added
20221001.11	83	Language added
20221001.12	84-85	Language added/removed
20221001.13	98	Language added/removed
20221001.14	100	Language added
20221001.15	122	Peer-to-Peer language added
20221001.16	123	Tiering Exception removed
20221001.17	164	Link to Health & Drug Plan Quality & Performance Rating updated
20221001.18	165	"2020" changed to "2022"

Update 20220701

Correction	Page	Description
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20220701.01	56	EFT process updated
20220701.02	57	Credentialing process for practitioners updated
20220701.03	58	Language added to Anesthesiologist
20220701.04	59	Language added to CRNA; Dentist – Endodontist, Periodontist, & Prosthodontist added
20220701.05	60	Language added to Hospital-Based
20220701.06	61	Oral & Maxillofacial surgeon updated; Language added to Pathologist
20220701.07	63	Credentialing process for Behavioral Health providers/practitioners updated; Language added to Radiologist; “Exclusion” changed to “Exception”
20220701.08	78	Nurse Practitioner – Oncology removed from list; Added Nurse Practitioner – Neonatal and Nurse Practitioner – Pediatrics to list
20220701.09	91	Hyperlink changed
20220701.10	125	“Information Systems” changed to “Enterprise Information Technology”
20220701.11	168	Corrected Bills section added
20220701.12	199	Comma added; “of” replaced with “and”

Update 20220401

Correction	Page	Description
20220401.01	9	Language added
20220401.2	10	Language added
20220401.3	11	Link changed
20220401.4	14	Link changed
20220401.5	22	Language added
20220401.6	23-27	Language added/Benefits grid updated
20220401.7	58	Language added
20220401.8	59	Language added

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20220401.9	62	Language removed
20220401.10	65	Radiologist title updated
20220401.11	90	Language added
20220401.12	91	Language added
20220401.13	92	Language added
20220401.14	93	Language added
20220401.15	94	Language added
20220401.16	96	Language added
20220401.17	100	Language added
20220401.18	102	Language added
20220401.19	103	Language added
20220401.20	108	Language added
20220401.21	112	Major section addition
20220401.22	115	Language added
20220401.23	116	Language added
20220401.24	117	Language added
20220401.25	118	Language added
20220401.26	119	Language added
20220401.27	124	Language added
20220401.28	126	Language added
20220401.29	127	Language added
20220401.30	128	Language added
20220401.31	129	Language added
20220401.32	130	Language added
20220401.33	131	Language added
20220401.34	132	Language added

20220401.35	133	Language added
20220401.36	134	Language added
20220401.37	135	Language added
20220401.38	136	Language added
20220401.39	137	Language added
20220401.40	139	Language added
20220401.41	140	Language added
20220401.42	141	Language added
20220401.43	142	Language added
20220401.44	142-154	Prior Authorization Review section addition
20220401.45	158	Language added
20220401.46	159-161	Medical Policy addition
20220401.47	166	2022 Measurement Year Scorecard updated
20220401.48	169	Language added
20220401.49	170	Language added
20220401.50	171	Language added
20220401.51	172	Language added
20220401.52	173	Language added
20220401.53	176	Language added
20220401.54	177-185	CMS 1500 Quick Reference Guide Updated
20220401.55	185	Language added
20220401.56	187	Language added
20220401.57	188	Language added
20220401.58	192	Language added

20220401.59	193	Therapy and Rehab Services section added
20220401.60	194	Language added
20220401.61	195	Language added
20220401.62	196	Language added

Update 20220101

Correction	Page	Description
20220101.01	16	Removed "To arrange Behavioral Health Services."
20220101.02	66	Reworded "Acupuncturist" language
20220101.03	68	Removed Interventional Radiology and related language; Added language
20220101.04	69	Added "Obstetrics & Gynecology" and related language
20220101.05	71	Added Diagnostic Radiology and Interventional Radiology and related language; Removed description in Radiology title
20220101.06	93	Language added to Sleep Labs
20220101.07	118	Language added/removed
20220101.08	132	Removed "tier exception or"
20220101.09	133	Removed "on any tier" and "tier exception or"
20220101.10	134	Removed "tier exception and" language, other language removed

Update 20211001

Correction	Page	Description
20211001.01	64	Note added
20211001.02	100	Note added
20211001.03	114	Changes to Part B Drug Screen section
20211001.04	114	Removed " 's" from BlueCare Plus
20211001.05	117	Changed "Psych" to "Psychiatric" in table

20211001.06	155-156	Language changed in PDRP
20211001.07	234	REM language modified to be high level per TDCI deficiency #1

Update 20210701

Correction	Page	Description
20210701.01	36	Language added
20210701.02	37	Language added
20210701.03	61-99	Credentialing section changed to match the Commercial and BlueCare Credentialing sections
20210701.04	112	Language added
20210701.05	115	Language removed/added
20210701.06	116	Language added
20210701.07	123	Language added
20210701.08	130	Updated formulary hyperlink
20210701.09	164	Language added
20210701.10	192-195	Language removed/added
20210701.11	239	Language added
20210701.12	256	Change of Ownership attachment added

Update 20210401

Correction	Page	Description
20210401.01	8	XIV. Appeals and Grievances TOC – switched “critical incidents” to “reportable event management”
20210401.02	15	Changed contact number
20210401.03	69-76	Language added
20210401.04	97	Added “/Neuropsychological” to table entry “psychological testing” as well as to “psychological testing” near bottom of page

20210401.05	103	9. Behavioral Health Quality Management - Added/Removed language
20210401.06	104	9. Behavioral Health Quality Management - Added/Removed Language
20210401.07	107	N. Over The Counter - \$300 changed to \$315
20210401.08	111	Changed hyperlink to direct to the formulary
20210401.09	130	D. Prior Authorization - Language added/removed from list
20210401.10	213-223	C. BlueCare Plus Choice (FIDE) Critical Incidents – Changed entirety of section including title to reflect “reportable event management”
20210401.11	221	Added bullet “COVID-19 test results (positive and negative results only)”
20210401.12	Footer	Added version suffix to footer

Update 20210101

Correction	Page	Description
20210101.01	16	Replaced phone number in 3. Important Contact Info
20210101.02	93	Removed language from D. Part B Drugs
20210101.03	93	Correction to 1 st bullet under Part B. Drugs Include:
20210101.04	93	Language added to 5 th bullet under Part B. Drugs Include:
20210101.05	103	Language added to Behavioral Health Quality Management
20210101.06	103	Language added to Behavioral Health Quality Management

Update 20201001

Correction	Page	Description
20201001.01	15	Updated to the Important Contact Information Grid
20201001.02	93	Updates to language regarding Part D Drugs in Chapter V, Section D.
20201001.03	102 to	Updates to Chapter V, Section I, Sub-Section 9 for Behavioral Health Quality Management.

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	10 4	
2020100 1.04	10 8	Addition of the Nurse Line number to Chapter V, Section T.
2020100 1.05	11 1	Removal of Part D language from Chapter VII.
2020100 1.06	12 3 to 12 5	Changes Case Management to Care Management in Chapter IX, Section B, E, and H.
2020100 1.07	13 1	Addition of language regarding HH Aid and PDN Missed Visits in Chapter X, Section F.
2020100 1.08	20 8	Addition of language regarding Advanced Beneficiary Notice (ABN) in Chapter XIV, Section A, Subsection 6.
2020100 1.09	21 4	Update to the BlueCare Plus FIDE fax number for written critical incident reports in Chapter XIV, Section C.

Update 20200701

Correction	Page	Description
20200701. 01	12	Updated link to the Business Code of Conduct.
20200701. 02	25 to 26	Language added to Chapter III explaining seamless enrollment and adding more information for the Special Enrollment Period.
20200701. 03	35	Updated the PCP Change Form.
20200701. 04	85 to 86	Updated screenshots added to reflect updated BlueCare Plus webpages.
20200701. 05	98	"CSU" added to footnote at bottom of Chapter I, Section 3.
20200701. 06	98	Updates to Chapter I, Section 4 related authorization requests.
20200701. 07	100	Updates to Chapter I, Section 8 to clarify requirements are specific to outpatient treatment providers.
20200701. 08	102	Updates to Chapter I, Section 8 to remove consent requirements related to adolescents.

20200701.09	104 to 105	Updates to Chapter I, Section 9 to revise language for complaint investigation, reporting of adverse occurrences, and site visit reviews.
20200701.10	211 to 213	Updates to process for Critical Incident reporting in Chapter XIV, Section C.

Update 20200401

Correction	Page	Description
20200401.01	97 to 98	Additional of Medication Assisted Treatment as benefit to Chapter V, Section I, subsection 3.
20200401.02	112	Updates to guidance for locating the Pharmacy Directory in Chapter VII, Section A.
20200401.03	114	Updated link to Coverage Determination form in Chapter VII, Section A.
20200401.04	122 to 127	Updates to chapter IX to reflect implementation of FIDE SNP and case management language updates.
20200401.05	130; 132-133	Updates to Prior Authorization requirements in Chapter X.
20200401.06	139	New Section D, Quality Incentive Program, added to Chapter XI.
20200401.07	192	Updates to Quick Reference Guide Link in Chapter XII, Section A, subsection 6.

Update 20200101

Correction	Page	Description
20200101.01	Entire Manual	Additional changes to reflect implementation of the FIDE SNP product (BlueCare Plus Choice).
20200101.02	26 to 31	Updates to benefits for 2020 calendar year in Chapter III, Section B.
20200101.03	32	Updated language added related to BlueCare Plus Choice Member ID Card in Chapter III, Section C.
20200101.04	36	Updates to Provider Change Form instructions in Chapter IV, Section A.

2020010 1.05	37 to 41	Miscellaneous language clean-up.
2020010 1.06	46 to 47	Language updates to participation standards in Chapter IV, Section A, subsection 6.
2020010 1.07	67 to 76	Language updates to credentialing requirements in Chapter IV, Section B, subsection 3.
2020010 1.08	79 to 80	Additional requirement added related to CMS screening requirements in Chapter IV, Section B, subsection 5.
2020010 1.09	89	Language added to Chapter V introduction regarding BlueCare Plus Choice Medicaid benefits.
2020010 1.10	93	Language revised in Chapter V, Section C to reflect 2020 benefits.
2020010 1.11	96 to 98	Language revised in Chapter V, Section I related to Behavioral Health services.
2020010 1.12	108	Language revised in Chapter V, Section S & T to reflect 2020 benefits.
2020010 1.13	112	Language revisions in Chapter VII, Section A related to the redetermination process.
2020010 1.14	129	Language added to Chapter X, Section A regarding BlueCare Plus Choice Medicaid benefits.
2020010 1.15	129 to 131	Language revisions to prior authorization requirements in Chapter X, Section D.
2020010 1.16	133	Language revisions to prior authorization timeframes in Chapter X, Section J.
2020010 1.17	137 to 139	Language updates to STARS information in Chapter XI, Section C.
2020010 1.18	186	Updated references to ICD-9 to ICD-10 in Chapter XIII, Section A.
2020010 1.19	210 to 212	New Section C added to Chapter XIV for BlueCare Plus Choice FIDE Critical Incidents

Update 20191001

Correction	Page	Description
20191001. 01	Entire Manual	Changes to reflect implementation of the FIDE SNP product (BlueCare Plus Choice).

D-SNP

20191001.02	31 to 32	Updated image for the BlueCare Plus D-SNP ID Card and added image for the BlueCare Plus Choice ID Card.
20191001.03	34	Updated fax number for PCP Change Team.
20191001.04	35	Updated PCP Change Form.
20191001.05	95	Removal of Member Outreach subsection from Chapter V, section I.
20191001.06	97	Updated instructions for contacting BlueCare Plus provider network management.
20191001.07	103	Language updates to Chapter V, Section J related to Dental Services.
20191001.08	106	Language updates to Chapter V, Section S related to Vision Services.
20191001.09	107 to 108	Note added to Chapter VI, Section A related to benefits traditionally excluded from BlueCare Plus that may be considered to be covered benefits for BlueCare Plus Choice.
20191001.10	112	Updates to Chapter VII, Section B specific to Member ID Cards redirecting the reader to Chapter III, Section C to view Member ID card images.
20191001.11	113 to 133	Miscellaneous terminology updates (care coordination to case management) to Chapter VIII, Chapter IX, and Chapter X.
20191001.12	143 to 166	Updates to claims filing instructions in Chapter XII, Section B and Section C.

Update 20190701

Correction	Page	Description
20190701.01	Entire Manual	Replaced “BlueAccess” with “Avality” including updates for links and access information.
20190701.02	14	Behavioral Health Prior Authorization contact phone and contact fax line updated. Corrected Link for Title VI information.
20190701.03	16	Changed Tennessee Health Connection to TennCare Connect in Important Contact Information table.

20190701.04	38 to 41	Updates to Provider Requirements Chapter IV, Section A, Subsections 3, 4, and 5 including large revisions to provider participation appeal processes.
20190701.05	92	Revised language in Chapter V, Section D.
20190701.06	95 to 96	Revised Cover Services Chart in Chapter V, Section I, Subsection 4
20190701.07	105 to 106	Updates to benefit limits in Chapter V, Section M, N, and R.
20190701.08	109	Language revisions to entire Chapter
20190701.09	127 to 133	Language revisions in Chapter X, Sections A and M
20190701.10	179	New section added to Chapter XII for Reimbursement General Provisions
20190701.11	198 to 199	Updated Appeals Process Charts

Update 20190401

Correction	Page	Description
20190401.01	98	Minor updates to fix spelling and grammar errors.
20190401.02	104 to 105	Updates to treatment record requirements.
20190401.03	108	Updated hyperlink to Behavioral Health Adverse Occurrence Reporting Form.
20190401.04	115 to 118	Updates to Pharmacy Chapter including contact information and prior authorization.
20190401.05	133	Additional language added to UM Chapter related to requirements for BH services.

Update 20190101

Correction	Page	Description
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2019010 1.01	Entire Manual	Rearranging the order of some Chapters and section-realignment.
2019010 1.02	12	Removal of content from Chapter I (Introduction), Section C (Provider Manual Requirements); content was moved to Chapter IV (Provider Requirements), Section B (Provider Credentialing).
2019010 1.03	14 to 22	Updates to content and phone numbers in Chapter II (Administrative).
2019010 1.04	23 to 36	Addition of significant language to Chapter III (Member Enrollment) and significant revisions to Section B (Summary of Benefits).
2019010 1.05	71 to 73	Removal of credentialing requirements for non-applicable specialties in Chapter IV (Provider Requirements), Section B (Provider Credentialing)
2019010 1.06	81 to 84	Updated contact hours for eBusiness Solutions in Chapter IV (Provider Requirements), Section C (Electronic Data Interchange EDI).
2019010 1.07	93 to 114	Language revisions and language additions in Chapter V (General Guidelines for Benefits).
2019010 1.08	115 to 116	Minor language revisions to Chapter VI (Non-Covered Benefits).
2019010 1.09	128 to 132	Minor language revisions to Chapter IX (Care Management).
2019010 1.10	135	Updates to Prior Authorization Requirements in Chapter X (Utilization Management), Section D (Prior Authorization).
2019010 1.11	140	Removal of Section M (Member Appeal Process) in Chapter X (Utilization Management).
2019010 1.12	146 to 183	Minor language revisions in Chapter XII (Billing and Reimbursement).
2019010 1.13	174 to 176	New Readmission Policy added in Chapter XII (Billing and Reimbursement).
2019010 1.14	195 to 210	New Chapter XIV (Appeals and Grievances) created to house all appeals and grievance content.

Update 20181001

Correction	Page	Description
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20181001.01	Entire Manual	Formatting updates to add consistency to text font, text size, and content alignment.
20181001.02	Entire Manual	Changing “BlueCare Plus HMO D-SNP” to “BlueCare Plus”
20181001.03	Entire Manual	Correcting links for www.bcbst.com and www.bluecareplus.bcbst.com .
20181001.04	Entire Manual	Changing “Bureau of TennCare” to “Division of TennCare”
20181001.05	13	Updated Provider Manual Requirements Chart
20181001.06	17	Updated Contact Information Chart
20181001.07	20	Language changes to reflect online fraud reporting process
20181001.08	22	Updating link for reporting suspected TennCare recipient fraud and/or abuse
20181001.09	27 to 53	Addition of new language to <i>Chapter II. Section E. Provider Networks</i> to bring the content into alignment with the other BCBST Provider Manuals.
20181001.10	53 to 71	Addition of new language to <i>Chapter II. Section F. Provider Credentialing</i> to bring the content into alignment with the other BCBST Provider Manuals.
20181001.11	103	Correcting TennCare links for provider information, member information, and LTSS information.
20181001.12	103	Updated BlueCare Plus Summary of Benefits Chart
20181001.13	113 to 127	Significant revisions to <i>Chapter IV. General Guidelines for Benefits</i> impacting every existing section with additions of new sections.
20181001.14	128 to 129	Significant revisions to <i>Chapter V. Non-Covered Benefits</i> impacting every existing section with removal of sections.
20181001.15	137 to 143	Significant revisions to Chapter VIII. Model of Care (MOC) D-SNP
20181001.16	144 to 145	Revisions to Chapter IX. Section C. Discharge Planning/Transition of Care

20181001.17	150 to 156	Significant revisions to <i>Chapter X. Utilization Management</i> including new sections as well as removed sections
20181001.18	182	Removal of information pertaining to "Readmission Quality Program"
20181001.19	233 to 237	Language revisions within Chapter XIV. Quality Improvement Program to provide process clarity

Update 20170609

Correcti on	P a g e	Description
20170609.1	30	Inserted Network Participation Criteria
20170609.2	118	Removed BlueSource Provider Information CD . Information now communicated through BlueAlert newsletter and manual changes.
20170609.3	58	Adding Clinical Practice Guidelines
20170609.4	126	Addition of coordination of member's care with PCPs and other treating providers
20170609.5	86	Updating Vision allowance for supplemental benefit
20170609.6	86	Updating Transportation supplemental benefit
20170609.7	54	Updating ecomm URL
20170609.8	55	Updating ecomm URL
20170609.9	87	Updating BluePerks URL

Update 20170412

Correcti on	P a g e	Description
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	g e	
2017041 2.1	1 3	Changing URL for Interpretation Services (Click on Interpretation for change) from http://www.usdoj.gov/crt/cor/coord/titlevi.htm to www.fhwa.dot.gov/civilrights/programs/tvi.cfm
2017041 2.2	1 7	Changing URL for Fraud and Abuse (Click on Fraud and Abuse) from http://www.bcbst.com/fraud/report.shtml to www.bcbst.com/fraud/index.page?
2017041 2.3	1 6 5	Changing Skilled Nursing Fax Form (Click on Form for change) from http://www.bcbst.com/providers/bcbst-medicare/forms.shtml and fax to 1-888-535-5243 to bluecareplus.bcbst.com/docs/providers/UM_Skilled_Nursing_Facility_Request_Fax.pdf
2017041 2.4	1 7 9	Changing URL for CAHPS (Click on CAHPS for change) from http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/CAHPS-Reports.html to www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS
2017041 2.5	1 8 2	Changing URL for Health Outcomes Survey (HOS) (Click on Health Outcomes for change) from www.hosonline.org/Content/Default.aspx to www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html
2017041 2.6		Adding URL (click on URL) www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf to MSP section

Update 20170313

Correcti on	P a g e	Description
2017031 3.1	2 0	Adding Education of Employees , Contract and Agents to Table of Contents
2017031 3.2	0 3	Adding Non-Discrimination to Table of Contents
2017031 3.3	2 0	Add section for Non-Discrimination
2017031 3.4	5 3	Changing sentence to read: A physician may request To obtain an expedited determination, by calling us at 1-866-789-6314

2017031 3.5	5 4	Adding Provider Dispute Procedure
2017031 3.6	1 6 0	Adding Re-Admission Reimbursement and Quality Program Information
2017031 3.7	0 2	Updating page numbers to Table of Contents to reflect additional information

Update 20150624

Correction	P a g e	Description
20150624. 1	1 6 6	Removed " CMS1450using "
20150624. 2	1 6 6	Changed TOB 33X to 32X as BlueCare Plus does not follow the same Medicare reimbursement methodology as Original Medicare. CMS Internet Only Manual, Publication 100-04, Chapter 10, Section 40.2 "HH PPS applies only to Medicare fee-for-service".
20150624. 3	9 6	Removed "T" from PCP
20150624. 4	9 6	Changed " meetings " to " reviews "
20150624. 5	9 6	Changed " packet " to "document"
20150624. 6	9 6	Changed "meetings" to " reviews "
20150624. 7	9 6	Added " d " to " an " for and
20150624. 8	9 6	Added additional paragraph for the BlueCare Plus ICT process
20150624. 9	9 6	Correct from member to member's
20150624. 10	9 6	Corrected spelling from wither to whether

20150624. 11	9 6	Added electronically or by fax to method of distributing ICT document
20150624. 12	1 6 1	Remove “or” DUPLICATE

Update 20141110

Correction	Page	Description
20141110. 1	1 6 6	Addition of National Drug Code Billing instructions including billing information regarding the filing a claim with an NDC number
20141110. 2	1 1 8	Addition of Observation Notifications information. Adding observation notification requirements and procedure.
20141110. 3	1 6 6	Correcting “provider” to “providing”
20141110. 4	1 7 0	Changing CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes) and encounter data submitted by MA plans to establish risk scores to the following; CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes and successor codes) and encounter data submitted by MA plans to establish risk scores
20141110. 5	1 7 0	The primary source of encounter data or ICD-9 codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review. The primary source of encounter data or ICD-9 codes and successor codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.
20141110. 6	1 7 0	CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and with supporting documentation in their medical record. CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and successor codes with supporting documentation in their medical record.

20141110. 7	1 7 0	<ul style="list-style-type: none"> ➤ Accurately reporting ICD-9-CM diagnosis codes to the highest level of specificity (critical as this determines disease severity). ➤ Accurately reporting ICD-9-CM diagnosis codes and successor codes to the highest level of specificity (critical as this determines disease severity).
20141110. 8	1 7 1	<p>Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM coding specificity.</p> <p>Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM and successor codes coding specificity.</p>
20141110. 9	1 7 1	<p>Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-9-CM codes, including:</p> <p>Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-9-CM codes and successor codes, including:</p>
20141110. 10	1 7 1	<p>Maintaining accurate and complete medical records (ICD-9-CM codes must be submitted with proper documentation)</p> <p>Maintaining accurate and complete medical records (ICD-9-CM codes and successor codes must be submitted with proper documentation).</p>
20141110. 11	1 7 1	<p>It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-9-CM code of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.</p> <p>It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-9-CM code and successor codes of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.</p>
20141110. 12	1 7 2	<p>Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code on the date of service, and are signed and dated by the physician or physician extender).</p> <p>Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code and successor codes on the date of service, and are signed and dated by the physician or physician extender).</p>
20141110. 13	1 5 8	<p>The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM).</p>

		The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM and successor codes).
20141110.14	1 7 7	1 st Paragraph - Corrected spelling error from " Prinvate " to private in the first paragraph.
20141110.15	1 7 7	2 nd Paragraph – Changed " chhosng " to "choosing"
20141110.16	7 5	Removing - BlueCare Plus partners with ValueOptions ® of Tennessee to administer behavioral health care services for its BlueCare Plus members. ValueOptions® is responsible for coordinating the provision of covered behavioral health services, establishing and managing a provider network, credentialing and contracting with providers. Providers interested in contracting with ValueOptions® can call 1-800-397-1630. Minimum network criteria required for participation in a ValueOptions® provider network can be found online at http://www.valueoptions.com/providers/Forms/Administrative/Provider_Credentialing_Criteria_Checklist.pdf .
20141110.17	7 5	Replacing the name ValueOptions with BlueCare Plus and adding http://www.bcbst.com/providers/contracting-credentialing.page? - BlueCare Plus utilizes ValueOptions ® for credentialing and contracting of Behavioral Health Practitioners. All providers who participate in a ValueOptions® network must be credentialed/recredentialed according to ValueOptions® requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit www.valueoptions.com provider site and select "Forms" or call the National Provider line at 1-800-397-1630.
20141110.18	8 2	Removing - Cosmetic Surgery from Non-Covered Benefits; Section C Custodial Care to new section Created Section E for Cosmetic Surgery Cosmetic surgery and expenses incurred in connection with the cosmetic surgery are not covered from under Non-Covered Benefits
20141110.19	8	Addition of the BlueCare Plus Manual Change Document
20141110.20	7 6	Replacing " ValueOptions " with BlueCare Plus
20141110.21	7 6	Replacing " ValueOptions " with BlueCare Plus

20141110. 22	7 6	Replacing " ValueOptions " with BlueCare Plus
20141110. 23	7 7	Replacing " ValueOptions " with BlueCare Plus
20141110.2 4	7 6	Removing " valueoptions.com "
20141110. 25	7 7	Removing the word " and "

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Attachment I: Change of Ownership (CHOW) Policy

The change of ownership requirements in this Policy only apply to facility and professional group provider types. It is the responsibility of the entity or person acquiring a provider to provide BCBST at least 60 calendar days advance notice of any change of ownership (CHOW) which is defined as a (a) direct or indirect sale or other disposition of all or a majority of the assets of provider; (b) any transaction resulting in a change in the beneficial owner, directly or indirectly, of 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); (c) the lease of all or part of Provider's facility or (d) any other transaction that results in a change to the NPI or Tax ID of Provider. When such advance notice is not furnished, payment to the provider may be impacted. The requirements under this policy are in addition to, and do not replace or supersede, any notice or approval requirements triggered by a CHOW, "Change of Control," or assignment that are set forth in the provider's agreement with BCBST.

The person or entity acquiring a provider is required to submit a CHOW notification using the Provider Change of Ownership Notification Form on BCBST's website. The buyer must also furnish a copy of the executed bill of sale or purchase document (minus the purchase price) within five (5) business days of closing. Failure to provide this documentation within this timeframe, will result in the suspension of payments to the provider following the CHOW.

Network Managers will assist the person or entity that is acquiring provider in completing any applicable credentialing and contracting processes prior to the effective date of the CHOW.

The buyer may be given the option to assume the seller's provider agreement, enter into a new agreement, or a single case agreement at BCBST's discretion. If BCBST determines a new agreement is required, the rates of the seller are not guaranteed to transfer to the buyer.

Claims with dates of service prior to the effective date of the CHOW should be submitted using the provider's NPI and Tax Id prior to the CHOW. Once the CHOW transaction closes, all claims for dates of service after the effective date of the CHOW should be submitted using the provider's NPI and Tax ID after the CHOW reflecting any change resulting from the CHOW.

Providers that fail to notify BCBST of a CHOW at least 60 calendar days prior to the CHOW effective date may experience a gap in network participation and claims payment. If the buyer notifies BCBST at least 60 days prior to the effective date of the CHOW and BCBST agrees to maintain the seller's provider agreement or enter into a new provider agreement, the following will apply:

- The network effective date will be the CHOW effective date.
- Claims after the CHOW effective date will be reimbursed at 100% of the in-network rate subject to all applicable payment terms under the agreement.

Buyers that do not notify BCBST timely of a CHOW will be handled as follows:

- BCBST may terminate the provider's agreement.
- If credentialing or a new agreement is required, then the network effective date will be the later of the date credentialed or agreement execution, as applicable.
- If BCBST does not choose to terminate the provider's agreement, there nonetheless could be a gap in network participation for the facility or group.
- If BCBST does not choose to terminate the provider's agreement, claims for dates of service after the CHOW closing date will be reimbursed at 100% as of the network effective date instead of the CHOW effective date subject to all applicable payment terms under the agreement.