APRIL 2026

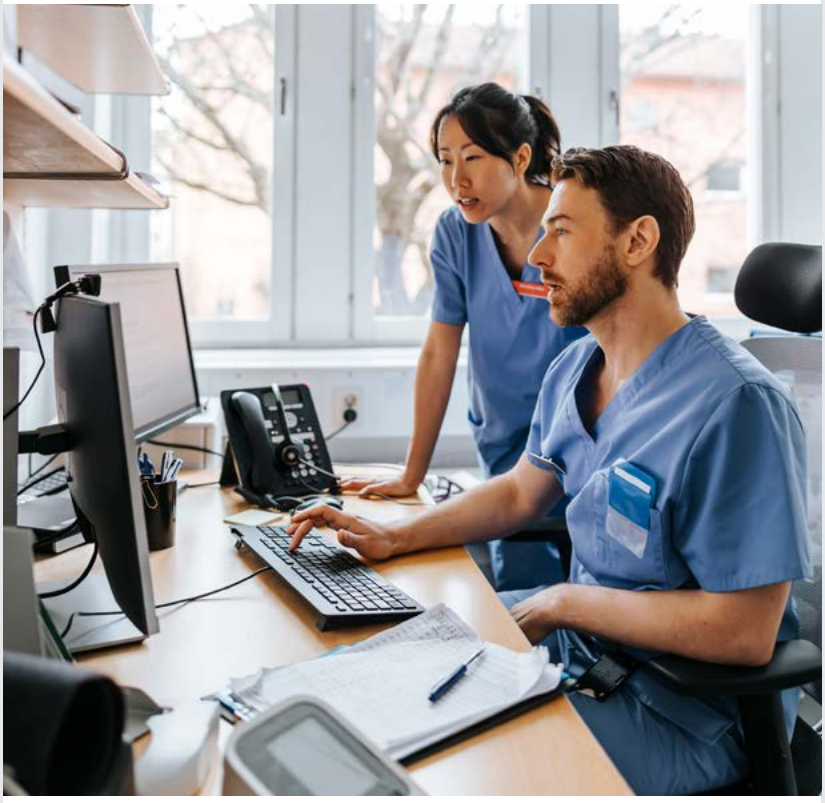
BlueAlert℠

of Tennessee | Mission driven FOR 80 Years

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

BlueCross BlueShield of Tennessee, Inc.

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



Keep Your Information Current

Please make sure your information is accurate in your CAQH account. Keeping this information current helps make sure that all communications from us are delivered successfully.

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Updates to the Durable Medical Equipment Network

As of **March 6, 2026**, we've partnered with CareCentrix to manage our durable medical equipment (DME) network. This change supports our broader efforts to address rising health care costs while maintaining members' access to the DME services and products you currently order for your patients.

For DME items that don't require prior authorization, BlueCross participating providers should place orders through the DME Navigator portal, which is managed by Parachute Health. Providers can access the portal via a tile in Availity®. Once in DME Navigator, they can select an in-network DME supplier.

For DME requiring prior authorization, providers should continue following the current BlueCross authorization process through Availity. Alternatively, if an order is sent directly to an in-network DME supplier, the supplier will initiate the prior authorization request.

We'll continue reviewing DME prior authorization requests in-house through **the first half of 2026**. After that, CareCentrix will begin reviewing and approving prior authorization requests for all networks.

If you have questions, please contact your Provider Network Manager.

Member ID Card Changes Coming for All Blue Plans by 2028

The Blue Cross Blue Shield Association is requiring all Blue plans to update Member ID cards by 2028. Updates will include removing the suitcase icon, which identifies members with the BlueCard benefit.

Please check Availity® to confirm a member's benefits or eligibility.

We're still in the planning phase, but you may start seeing updated cards from members with other Blue plans or BlueCard benefits soon. Continue to check BlueAlert for updates.

Change of Ownership Reminder

If you're acquiring or being acquired by a provider facility or group, you must give us at least 60 days advance written notice of change of ownership (CHOW). You also need to submit a CHOW notification using the **Provider Change of Ownership Notification Form**. Once the transaction has closed, send us a copy of the executed bill of sale or purchase document (minus the purchase price) within five business days of closing. If you don't provide the required notice or documents, your payments could be impacted.

For more details about CHOW requirements, please consult your BlueCross provider agreement or check your Provider Administration Manual (PAM). You can also find additional information in the FAQs document **here**.

Stay Informed by Submitting Prior Authorizations in Availity

Submitting prior authorizations through the **Prior Authorization Tool** in Availity gives you more options and can make the decision process faster than submitting them directly to Cohere.

When you submit a prior authorization in Availity:

- The system sends your prior authorization to the appropriate place/vendor.
- Availity verifies the Member ID is active.
- You can verify the status of authorizations.
- You can easily locate authorization letters.
- You can quickly update existing authorizations.

If you have questions about submitting a prior authorization in Availity, please call **(423) 535-5717, option 2**, or contact your **eBusiness Network Manager**.

A Faster Way to Receive Important Communications From Us

You can receive contract-related communications – including fee schedule updates – up to three days faster by switching from mail to email. By selecting email and adding a contact name and email address, you can also request email for credentialing, network operations, network updates, quality and clinical information, and financial updates.

You can update your contact preferences **by following these steps** in **Availity**. Simply select email instead of mail for all types of communication and add a contact name and email address for each one.

Follow these steps in Availity:

1. Log in to BlueCross **Payer Spaces**.
2. Select the **Contact Preferences & Communication Viewer** tile.
3. Choose your **Contact Type**.
4. Select your **Organization** and **Tax ID**. (Tax ID is a newly added feature that lets you select a specific provider based on Tax ID. You can update contact information for all Tax IDs, including the primary Tax ID associated with the corresponding NPI.)
5. Pick a provider from the drop-down list or manually enter the provider's **NPI** and click **Submit**.
6. Follow the remaining cues and check the email **Opt In** box. Make sure email is the first option in the **Communication Preference** list on the right side. When finished, click **Save & Submit**. You can apply the same updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all contact types you have access to. In some cases, you may find it takes time to receive these messages through your newly specified email, and you may temporarily receive them as you did before.

   Tip: If you don't see your name in the drop-down list, you can add it through the **Manage My Organization** dashboard. For the contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.

A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. If you have questions, please log in to Availity or contact eBusiness Technical Support at **(423) 535-5717, option 2**.

New Inquiries, Reconsiderations and Appeals Tool in Availity

Our new online inquiries, reconsiderations and appeals tool is now available in Availity. Previously, we accepted these submissions by phone, fax, mail and email. But as of **April 1, 2026**, all providers are required to submit inquiries, reconsiderations and appeals through our claims dispute tool in Availity. We're no longer accepting these submissions by fax, mail or email.

For more information, please keep an eye out for additional resources in our Payer Spaces in Availity or contact your **eBusiness Network Manager**.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless specifically identified below.

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific Commercial networks. Depending on the region, a provider may be part of one or several of these networks.

BH providers are contracted into the BH Comprehensive Network, which automatically includes all Commercial networks (P, S, L and E). These providers are considered in-network for any member with a Commercial plan.

Multi-Specialty Group Practices

Some health care group practices include both medical and BH providers. While the BH provider may be in-network due to the BH Comprehensive Network, the medical provider in the same practice might not be in-network for the member's specific Commercial plan.

Example 1:

- The member's policy uses Network S.
- The health care group practice is contracted in Network P and the BH Comprehensive Network. However, the provider isn't contracted for Network S.
- In this example, the member would have in-network benefits with the BH provider, because the BH Comprehensive Network covers all networks.
- The medical providers in the group would be out-of-network for the member because they only participate in Network P.

Example 2:

- The member's policy uses Network S.
- The health care group practice is contracted in Network P and S and the BH Comprehensive Network.
- In this example, the member would have in-network benefits with the BH provider and medical provider, because the BH Comprehensive Network covers all networks, and the medical provider is in the member's network.

Updates with this clarification are being made to the Provider Quick Reference Guide.

Future Updates: See the Latest and What Changes Are on the Way

Please review the table below to find the latest information from us and what changes are on the way. If you have questions, please contact your Provider Network Manager. If you're unsure who that is, go to **My BlueCross Contact**. For questions about medical policy updates, please send an email to **medical_policy@bcbst.com**.

Update Type	Availability	Where to Find It
Coding Updates	60 days before the effective date	Go to the **Coverage & Claims** page on **provider.bcbst.com**. Updates are located under **Coding Updates** in the **Coding Information** section.
Lab Testing Policies	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**.
Upcoming Prior Authorization Changes	60 days before the effective date	Go to the **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Upcoming Prior Authorization** Changes in the **News & Updates** section.
Pharmacy Updates	Updated as needed	Download a summary of select upcoming drug prior authorization criteria changes **here**.
Medical Policy Updates	60 days before the effective date	Go to the **Manuals, Policies & Guidelines** page on **provider.bcbst.com**. Updates are located under **Coverage**.

BlueCare Tennessee

*This information applies to BlueCare℠, TennCare*Select* and CoverKids plans unless specifically identified below.*

Process Reminder: Requirements for Provider Subcontracting

Providers caring for members with BlueCare, TennCare*Select* and CoverKids coverage may not subcontract any part of contracted services without written approval from BlueCare Tennessee. Without prior agreement, we may deny claims for services provided by a subcontractor, and previous payment may be subject to recoupment.

We're updating the form used to request approval for all subcontractors. Soon, providers in our networks must submit the BlueCare Tennessee Provider Subcontracting Form with Attestation to request subcontracting approval. We'll publish another BlueAlert article when this form is available. Providers must also complete the **Exhibit for Subcontractors Compliance with Terms of BlueCare Tennessee Provider Agreement**, which isn't changing.

All provider subcontractors must also meet these requirements:

- All employees and subcontractors supporting the BlueCare Tennessee contract must complete **Deficit Reduction Act/Fraud, Waste and Abuse Training**.
- Service records provided by subcontractors must be kept for at least 10 years after the agreement with BlueCare Tennessee expires, unless otherwise noted in the vendor contract.
- Subcontractors must verify that employees aren't listed on the **Office of the Inspector General List of Excluded Individuals and Entities**, **TennCare's Terminated Provider List**, or the **System for Award Management** databases before hiring and every month during employment.

If you're terminating a contract with a BlueCare Tennessee-approved subcontractor, please complete the **BlueCare Tennessee Subcontracting Termination Form**.

Please send all completed forms to **TennCare_Provider_Subcontracts@bcbst.com**.

How We Pay for Performing EPSDT and Sick Visits on the Same Day

TennCare Kids' screening guidelines say we can pay for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits done at the same time as other services. We reimburse both sick and well visits at 100% when performed on the same day.

Consider checking your patient roster in the Availity **Quality Care Rewards** application to see if each patient's up to date on preventive care.

For more information about billing EPSDT visits, please see our **EPSDT Provider Tool Kit**.

Note: The information in this article doesn't apply to CoverKids.

Reframing EPSDT: Helping Families See It as a Resource

Many parents and guardians think of EPSDT checkups as just another requirement. But EPSDT visits are essential to supporting children's long-term health. By helping families understand the value of these visits, you can strengthen relationships, improve outcomes and connect children to services they may not realize are covered.

EPSDT visits allow you to identify health concerns in children early—when they can be easier to treat. They also help children stay on track with growth, learning and emotional well being. You can provide them with specialist care, mental health support and other medically necessary services.

These visits also give families dedicated time with you. Caregivers can ask questions, share concerns and receive guidance tailored to their child's needs.

During an EPSDT visit, you'll review the child's health history and complete a physical exam, vision and hearing screenings, immunizations, and any needed lab work. Developmental or behavioral screenings may also be completed based on age or concerns.

It's also important to remind families that TennCare members receive free annual well-child visits and follow-up care until age 21.

For more tools and guidance, visit the **EPSDT Provider Tool Kit**.

Note: The information in this article doesn't apply to CoverKids.

Dedicated Staff to Support Children in Foster Care

We have a specialized team to help foster families and our members in state custody. Our *Select*Kids team can help with scheduling appointments, handling out-of-state pharmacy needs, and addressing social determinants of health. They can also connect families to our care team as needed for help with healthy living, managing short- or long-term illness or injury, or more complex health needs.

Additionally, our *Select*Kids team works closely with the Department of Children's Services (DCS) and can serve as a liaison if you'd like extra support coordinating patient care.

Please let foster families know we're here to help. You and your patients' guardians can reach our care team by emailing **SelectKids_GM@bcbst.com** or calling **1-877-DCS-KIDS** (1-877-327-5437). We're available Monday through Friday from 8 a.m. to 6 p.m. ET. After hours, calls are automatically routed to our Nurseline.

Note: The information in this article only applies to TennCare*Select*.

Improving Maternal Health Among Black Women

April 11-17 is Black Maternal Health Week. This yearly recognition raises awareness of maternal health disparities faced by Black women.

According to the Tennessee Department of Health's 2024 Maternal Mortality in Tennessee Annual Report, 76% of all pregnancy-related deaths in 2022 were preventable, exposing the need for better prenatal care among expecting patients. The report also highlighted maternal mortality disparities between racial and ethnic groups, with non-Hispanic Black women bearing the greatest burden.

From 2020 to 2022, non-Hispanic Black women experienced the highest rate of pregnancy-related deaths compared to other groups — 1.8 times higher than non-Hispanic white women and 2.9 times higher than Hispanic women. Cardiovascular conditions accounted for 30% of these deaths and were the largest contributing factor. Infection was the second-largest contributor, accounting for 27%.

Our 2025 Health Equity Report shows Black women in Tennessee are less likely to get prenatal immunizations, timely prenatal care and postpartum care than Asian, Hispanic and white women.

Encouraging patients to get all recommended prenatal and postnatal care may serve to improve mortality rates across the state. Additionally, pregnant and postpartum patients with BlueCare Tennessee coverage can get a no-cost, at-home blood pressure cuff to help monitor their health. Providers can submit an order to an in-network DME provider for their patients to get their at-home cuff.

BlueCare Plus Tennessee

This information applies to our Medicare and Medicaid dual-eligible special needs plans unless specifically identified below.

Complete the 2026 Special Needs Plan Model of Care (MOC) Training

Providers participating in BlueCare Plus Tennessee special needs plans are contractually required to complete our MOC training after initial contracting, then every year afterward. This training promotes quality of care and cost effectiveness through coordinated care for our members with complex, chronic or catastrophic health care needs. You can access the online self-study training and attestation by **clicking here**.

BlueCare Plus Tennessee and Medicare Advantage

This information applies to our Medicare Advantage and BlueCare Plus Tennessee plans unless specifically identified below.

Post-Determination Peer-to-Peer Reviews No Longer Available April 1, 2026

Peer-to-peer (P2P) conversations have historically supported clinical dialogue related to inpatient versus observation determinations. To remain fully compliant with current CMS requirements, we're updating our P2P process.

What's Changing

We'll no longer offer post-determination P2P reviews for Medicare Advantage products, including BlueAdvantage and BlueCare Plus Tennessee. CMS requires that once an organization issues a determination — such as a denial of inpatient level of care — the determination can't be modified through informal mechanisms like P2P discussions. Any request to change a determination must go through the formal Medicare Advantage appeals process.

This guidance applies uniformly to all Medicare Advantage organizations and isn't plan-specific.

What Remains Available

Pre-determination P2P reviews remain available for all case types. These reviews allow:

- Clarification of clinical information
- Submission of additional documentation prior to a final decision
- Clinical dialogue before an organization issues a determination

This is the appropriate point in the review process where P2P discussions may influence outcomes.

After a Determination

If you disagree with a final determination or have new clinical information:

- The appropriate next step is the BlueAdvantage or BlueCare Plus Tennessee appeals process, which allows for submission of new evidence and ensures an independent, CMS-recognized review.

We're Here to Support You

We recognize this represents a change from longstanding practice and are committed to supporting you through:

- Predetermination P2P requests
- The appeals process
- Education and guidance

For questions or assistance, please contact your **Provider Relations representative** or refer to the **Provider Administrative Manual (PAM)** for detailed information.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless specifically identified below.

Provider Star Ratings Now Available in Availity

The Medicare Advantage Quality+ Partnership Program offers providers enhanced reimbursement for 4-Star and above quality scores and coding accuracy completed during the 2025 measurement period of Jan. 1 – Dec. 31, 2025. Participating providers can now view their 2025 Star rating in Availity.

- Go to the **Quality Care Rewards** application.
- Click the **Scorecards** tile.
- Go to the **Prior Year Scorecards** link under the **More Information** tile.
- The rating is **located at the top** of the scorecard.

Star ratings, as calculated by the previous year's performance, impact each provider's reimbursement rates. The new rates are effective April 1, 2026. Providers should refer to the rate attachment provided with their rate adjustment notification letters, mailed at the end of March, to see their new fee schedules.

Contract amendments contain information about each provider's base rate, the quality escalator and total earning potential.

Quality Corner

This information applies to all lines of business unless specifically identified below.

Quality Corner: Cervical Cancer Screening (CCS) Measure

Cervical cancer remains one of the most preventable cancers, and timely screening plays a key role in delivering high-quality care. The HEDIS Cervical Cancer Screening (CCS) measure evaluates whether women receive evidence-based screening at the recommended intervals.

U.S. Preventive Services Task Force (USPSTF) Screening Recommendations

Screening is recommended for patients assigned female at birth, ages 21 to 65, according to the following guidelines:

Ages 21–29:

- Perform cervical cytology (Pap smear) every three years.

Ages 30–65:

- Perform cervical cytology every three years,

  or

- High-risk HPV (hrHPV) testing every five years,

  or

- Co-testing with both Pap smear and hrHPV every five years.

Screening may be discontinued after age 65 if there has been adequate prior screening and no history of high-risk factors.

Tips and Best Practices to Help Improve Performance

- Submit claims with accurate codes, including:
  - Cervical Cytology (Pap): 88141-88143, 88147-88148, 88150
  - High-Risk HPV: 87624, 87625
  - Co-testing: G0476
  - Hysterectomy (cervix removal—total, complete, radical): 58150, 58260, 58210
- Add preventive screening names, dates and results to your note template.
- Address social risks like lack of insurance, cost and limited access in rural or low-income areas.
- For hysterectomy, confirm cervix removal and document that the patient is not eligible for CCS-E screening.

Pharmacy

This information applies to all lines of business unless specifically identified below.

Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Please **click here** to review important notices about prescribing changes, authorization guidelines and other items related to the TennCare Pharmacy Program.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

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Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	1-800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***Select*Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Seven days/week, 8 a.m. to 9 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice or facility:

Please visit our payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Provider Portal** website.

Questions? Call **1-800-924-7141**.