BlueCross BlueShield of Tennessee

JUNE 2026

BlueAlert℠

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 up to date in your CAQH account. This helps us reach you with important communications without delay.

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Updates to the Durable Medical Equipment Network

As of **March 6, 2026**, we've contracted 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 Parachute Health manages. You can access the portal via a tile in Availity®. Once in DME Navigator, you can select an in-network DME supplier.

For DME requiring prior authorization, continue following the current BlueCross prior authorization process through Availity. Or, if you send an order 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.

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**.

Update Your Contact Preference in Availity

To make sure you receive important provider enrollment and contracting information as soon as it's available, please update your **Contracting contact preference** in Availity.

When you select the Contracting contact preference, you'll receive email updates about contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies and annual performance ratings.

To update your preference, log in to BlueCross Payer Spaces in Availity. Open the **Contact Preferences & Communication Viewer** and select email for Contracting communications. Before saving your changes, be sure to add or confirm a contact name and email address.

If you need help, you can find a **Contact Preference Quick Reference Guide** under the **Payer Spaces Resources** tab. Please note that changes may not take effect right away, and you may continue to receive some communications by mail during the transition.

For extra help, contact **eBusiness Technical Support** at **423-535-5717, option 2**.

Inquiries, Reconsiderations and Appeals Must Be Submitted in Availity

Effective **April 1, 2026**, all providers submit inquiries, reconsiderations and appeals through our claims dispute tool in Availity.

What you need to know:

- We no longer accept submissions by fax, mail or email.
- This applies to:
  - In-network providers.
  - Out-of-network providers with a practicing address in Tennessee.*
- Forms are no longer required for reconsiderations or appeals.
  - You must still enter the reason for your request in the appropriate Availity field.
- If you identify an overpayment, submit it as a general inquiry in Availity.
  - Use this process until we announce a permanent overpayment submission option.
  - Previously, the "Think you have an overpayment" form was used.

For more information, please see our additional resources in our Payer Spaces in Availity or contact your **eBusiness Network Manager**.

*Please note, this doesn't apply to inquiries, reconsiderations or appeals for routine dental service claims performed by dental providers.

What Providers Need to Know When Reporting Spravato® Administration and Monitoring With Prolonged Services Codes

When records for Spravato-related claims are requested for audit review:

- Include the Spravato REMS Monitoring Form and all clinical documentation supporting medical necessity, administration and monitoring.
- If Spravato is purchased through a specialty distributor and billed with G2082/G2083, attach the invoice documenting drug acquisition. Bundled G-codes may only be billed when acquired through a specialty distributor.

What to include for administration and monitoring documentation:

- Document the names and credentials of all clinical staff involved in Spravato administration and monitoring, including any face to face time provided.
- Clearly identify who performed the monitoring (clinical staff under physician/QHP supervision vs. physician/other QHP) and include the total time documented for each role.
- Clearly differentiate clinical staff prolonged services time (99415/99416) from physician/other QHP prolonged services time (99417 or G2212 for MA/DSNP) in your documentation.
- Ensure all face to face time is documented when required and that total time supports each prolonged services unit reported.

Selecting Prolonged Services Codes

If monitoring is performed by clinical staff under physician supervision:

- Use 99415/99416 (Prolonged clinical staff services with physician supervision) when time thresholds are met. These codes:
  - May be reported with any level of office or other outpatient E/M visit.
  - Are limited to a maximum of two patients simultaneously per clinical staff member.
  - Follow the CPT® midpoint rule (one unit is attained when the midpoint of the time interval has passed).
- Refer to CPT® Codebook, Evaluation and Management, Prolonged Services, Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision regarding appropriate reporting of prolonged clinical staff service code(s) 99415/99416.
  - See CPT® Codebook: Reporting Prolonged Clinical Staff Time Table

Reporting Prolonged Clinical Staff Time

Code	Typical Clinical Staff Time	99415 Time Range (Minutes)	99415 Start Point (Minutes)
99202	29	59–103	104
99203	34	64–108	109
99204	41	71–115	116
99205	46	76–120	121
99211	16	46–90	91
99212	24	54–98	99
99213	27	57–101	102
99214	40	70–114	115
99215	45	75–119	120

If monitoring is performed by the physician/other QHP:

- Report the appropriate office/outpatient E/M code and add 99417 for prolonged services when 15 minute increments are attained beyond the E/M code's time.
- Refer to CPT® Codebook, Evaluation and Management, Prolonged Services, Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service regarding appropriate reporting of prolonged service code 99417.
  - See CPT® Codebook: Table 1. New Patient Total Duration

New Patient Total Duration

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75–89 minutes	99205 x 1 and 99417 x 1
90–104 minutes	99205 x 1 and 99417 x 2
105 minutes or more	99205 x 1 and 99417 x 3 or more for each additional 15 minutes

See CPT® Codebook: Table 2. Prolonged Services Total Time

Prolonged Services Total Time

Primary Code	Prolonged Services Code	Total Time to Report Initial Unit of Prolonged Services	Total Time to Report Second Unit of Prolonged Services
99205	99417	75	90
99215	99417	55	70
99223	99418	90	105
99223	99418	65	80
99236	99418	100	115
99245	99417	70	85
99255	99418	95	110
99306	99418	65	80
99310	99418	60	75
99345	99417	90	105
99350	99417	75	90
99483	99417	75	90

Medicare Advantage / BlueCare Plus Tennessee members

When administration and monitoring are performed by the physician/other QHP, use G2212 for prolonged services (do not use G2212 for clinical staff time). Refer to CMS MLN006764 – Evaluation and Management Services regarding guidelines for reporting prolonged services code G2212.

Commercial

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

Understanding the Behavioral Health (BH) Comprehensive Network

Medical providers are typically contracted for specific, regional commercial 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 only in Network P and the BH Comprehensive Network.
- 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 providers and medical providers, because the BH Comprehensive Network covers all networks, and the group is in the member's network.

Updates at a Glance: What's New and What's Coming

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[SM], TennCareSelect and CoverKids plans unless specifically identified below.

Billing for Prenatal and Postpartum Care

It's important to follow the correct billing steps when providing prenatal and postpartum services.

To receive the prenatal payment:

- Submit charges with Category II code 0500F and the associated $25 payment on the claim.
- Submit evaluation and management (E/M) codes (99202–99205 or 99211–99215) on the claim.
- Submit the Maternity Care Notification Form through Availity within 30 days of submitting the claim.

To receive the postpartum payment:

- Submit charges with Category II code 0503F and the associated $75 payment on the claim.
- Submit E/M code 59530 on the claim.
- During the postpartum period (seven to 84 days after delivery), you may submit two claims and receive two payments for postpartum care.
- What's changed: You don't need to include the delivery date on the claim.

Helping Members Through Pregnancy

We offer several benefits to support our members during and after their pregnancy. As their provider, you play an important role in connecting them to these resources.

Here are a few ways you can help your patients get the support they need:

- Submit the Maternity Care Management Form through Availity. This connects members to maternity benefits.
- Encourage members to download the CareTN app and enroll in the maternity program. The app offers helpful information on prenatal appointments, car seat safety, depression, anxiety and more.
- Talk with members about the BESMART program if they have opioid use disorder during or after pregnancy.
- Help them schedule a ride through Verida if they need help getting to appointments or picking up medications.

You can find these resources and more at **bluecare.bcbst.com**.

Join Us for the June 2026 EPSDT Virtual Coding Workshop

Please plan to attend the first EPSDT coding workshop of 2026 from **noon-1:30 p.m. ET (11 a.m.-12:30 p.m. CT)** on **June 11**. During the virtual session, we'll provide updates, and you'll hear from the Tennessee Chapter of the American Academy of Pediatrics.

Registration is required. Please **click here** and fill out the registration form to save your spot. We hope you can attend and look forward to connecting with you.

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

Be On The Lookout for Verida, Inc. Information Requests

Verida, Inc. conducts regular pre- and post-trip audits when BlueCare and TennCare*Select* members book rides to be sure the transportation is only for covered services and the visits go as scheduled. As part of these audits, Verida may call your office to verify patients' appointments. This is a normal part of their process, so you may give them the information they ask for.

Note: This doesn't apply to CoverKids members.

EPSDT Myths and Facts

What is EPSDT?

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits provide the regular preventive and diagnostic exams children need to stay healthy and get the treatment they need.

MYTH: An EPSDT visit is the same as a yearly check-up.

FACT: EPSDT visits address physical, behavioral and developmental screenings and services. They're much more comprehensive than a yearly exam.

MYTH: An EPSDT visit is only for young children.

FACT: EPSDT visits are covered for members 21 and younger. Despite having coverage, teens and young adults have the lowest rate of completing their EPSDT exams.

MYTH: Healthy kids don't need EPSDT visits.

FACT: EPSDT visits help catch concerns earlier, when they can be easier to treat. They should be seen as preventive care. Even kids who see many different specialists and providers should have regular EPSDT visits.

MYTH: You can't combine an EPSDT visit with a sports physical.

FACT: You can do both an EPSDT exam and sports physical at one appointment. But you can't replace an EPSDT exam with a sports physical. Benefits don't cover sports physicals, but they're a great opportunity for you to make sure the child also receives an EPSDT visit while there.

EPSDT care is important to the overall well-being of children. It provides comprehensive services and should be part of every eligible member's care.

Note: This article doesn't apply to CoverKids.

Helping Foster Families Choose the Right Care

When a child in foster care isn't feeling well, families tend to head to the ER—even when it's not an emergency. Providers can help redirect unnecessary ER visits by reinforcing when the ER is needed and pointing families to other care options that may be faster and more appropriate.

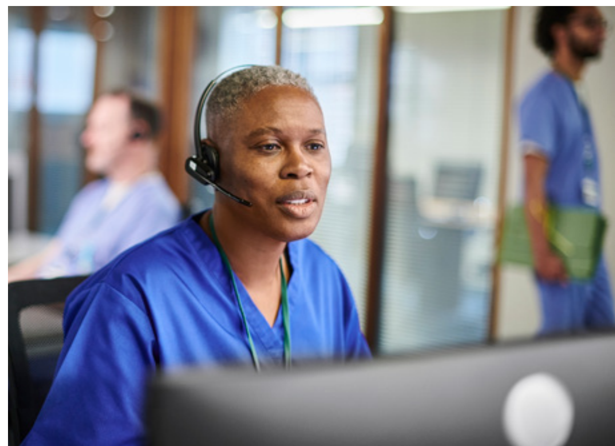
The ER should be reserved for true emergencies, like trouble breathing or serious injury. For non-emergency concerns, families should try to get the care they need through urgent care, their PCP or the 24/7 NurseLine.

Care After Hours with NurseLine

Our 24/7 NurseLine connects foster parents with trained pediatric nurses who help them decide the right next step—whether that's home care, seeing the PCP, visiting urgent care or going to the ER.

- Available 24/7, including holidays
- No extra cost
- Call **800-262-2873**

Encouraging NurseLine use helps children get the right care at the right time and reduces unnecessary ER visits.



New Provider Subcontracting Form Now Available

In the **April 2026 BlueAlert**, we let you know we were developing a new form for providers in our networks to use when requesting subcontracting approval. This form is now available and features several key updates, including:

- Adding an attestation for the subcontractor to complete that defines the frequencies of required screenings.
- Adding a requirement for providers to screen subcontractors against TennCare's Terminated Provider List.
- Removing the requirement for providers to screen subcontractors against the Social Security Death Master File.
- Removing subcontractor ownership information.

You can find the BlueCare Tennessee Provider Subcontracting Form with Attestation on the **Documents and Forms** page of **bluecare.bcbst.com/providers**. Choose **Administrative Information**, then expand the **Office Administration** drop-down menu.

Note: You'll also need to complete the **Exhibit for Subcontractors Compliance with Terms of BlueCare Tennessee Provider Agreement**, which hasn't changed.

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

Sign Up to Get Important Information Digitally

Later this year, you'll be able to get some BlueCare Tennessee communications digitally. If you sign up for emails from us, you'll get updates faster and get fewer printed materials.

If you haven't already, opt in to get electronic updates for all contact types. You can update your communication preferences in Availity. You can find a **Contact Preference Quick Reference Guide** with instructions to update your preferences under the **Payer Resources** tab in Availity.

If you have questions or need help, please call eBusiness Technical Support at **423-535-5717, option 2**, or contact your **eBusiness Network Manager**.

Please note, this only affects the delivery method for some BlueCare Tennessee materials. It doesn't affect provider policies, requirements or reimbursement rules, and you'll still be able to access all required materials.

We'll share more information, including the effective date and instructions for getting digital communications, in future issues of BlueAlert.

Important Reminders for Filing Crossover Claims

To help us correctly identify whether a claim is a crossover (cost share) or a secondary claim (including Medicare non-covered services), please follow these guidelines:

- Use the correct insurance indicator and policy number.
- Crossover (cost share) claims are identified by the claim filing indicator located in **the 2000B Loop (Subscriber Info)** section of your electronic claim.
- Use **"16"** in **SBR09** to show the claim is secondary to Medicare, a Dual Special Needs Plan, or a Medicare Advantage plan. For all secondary non-crossover claims, do not use "16" in the SBR09 for the 2000B Loop.
- The **2320 Loop (Other Subscriber Info)** includes the patient's other insurance. Continue using **MA, MB, OF** or **16** in SBR09 for Medicare or the appropriate commercial indicator (e.g., 12, BL, CI, HM) depending on the primary insurance type – just like you do today. You can view a full list of indicators **here**.

Using the correct indicators helps prevent claim denials, avoid payment delays and ensure accurate coordination of benefits.

Deadlines for Submitting Crossover Claims

Crossover claims should be limited to certain situations and should only occur after they've allowed at least 60 days for Medicare or D-SNP to cross the claim to BlueCare Tennessee.

Providers have 365 days from the date of service or 180 days from the paid date on the Medicare MSN-D-SNP EOB, whichever is greater, to submit a claim for cost-share reimbursement.

After the initial filing (within those timeframes), if BlueCare Tennessee rejects, returns or denies the claim, providers must resubmit the corrected claim within six months from the rejected, returned or denied date.

Submitting Claims vs. Reconsiderations in Availity

Choose the correct submission type to avoid delays and ensure faster payment.

Claims Denied for an EOB or MSN

If a claim denied because an Explanation of Benefits (EOB) or Medicare Summary Notice (MSN) was missing, a reconsideration isn't required.

What to do:

- Submit the claim as a new claim (not corrected).
- Attach the required EOB or MSN.

This process is more efficient and results in quicker payment than submitting a reconsideration. If you're concerned about duplicate denials, automation is in place to recognize the attached EOB/MSN so the claim isn't processed as a duplicate.

When to Submit a Reconsideration for BlueCare Tennessee

Reconsiderations may be submitted for claims denied due to:

- Timely filing
- Contract reimbursement
- Medicaid ID or disclosure issues
- Post payment audits
- Third party liability
- Code bundling or editing
- PCP denials

If your denial falls into one of these categories, you can submit a reconsideration through the claims dispute tool in Availity.

Reminder: If you're only submitting missing documentation (such as an EOB or MSN), resubmit the claim with the attachment instead of submitting a reconsideration.

BlueCare Plus Tennessee

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

CMS Releases Updated Medicare Outpatient Observation Notice (MOON)

The Office of Management and Budget has approved the CMS-updated MOON. The revised form features improvements to readability and design. It's effective immediately and expires on **Feb. 28, 2029**.

You must begin using the updated version. You're also required to deliver a MOON to Medicare beneficiaries and let them know they're outpatients receiving observation services—not inpatients at a hospital or critical access hospital.

For more instructions, visit the **CMS Claims Processing Manual (Pub. 10004), Chapter 30, Section 400.https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf**

Complete the 2026 Special Needs Plans 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.

Pre-Determination Peer-to-Peer (P2P) Review

A Pre-Determination P2P review is a doctor-to-doctor conversation that may be offered during a preservice review when a clinical decision requires physician judgment. This guidance applies only to services covered under our Medicare Advantage products (BlueAdvantage PPOSM and BlueCare Plus Tennessee) as outlined in the Provider Administration Manual. Services covered under other manuals or delegated programs follow their own program-specific policies and procedures.

When a P2P May Occur

A P2P is generally considered when:

- A prior authorization request is already in the system.
- Clinical documentation has been submitted and is under review.
- A potential adverse medical necessity decision is being considered.
- The requested discussion is between the member's provider and the plan medical director.
- There's an inpatient admission, planned inpatient procedure or continued stays or extension.
- You have level-of-care questions.

When a P2P Isn't Appropriate

- Administrative, technical or contractual denials or issues
- Retrospective or post-service reviews
- Requests not related to medical necessity review (e.g., covered benefits)

Keep in Mind

- P2Ps aren't appeals.
- Not every request will qualify.
- Availability depends on review status, eligibility of services under review and whether there's sufficient turnaround time.
- Required timeframes are set by CMS.

New Post-Acute Care Partnerships with tango and Wellsky®

We're working with **tango** and **WellSky** to support post-acute care services for Medicare and Medicaid dual-eligible special needs plans.

- Tango will manage skilled home health services, including nursing, therapy, aide and social work.
- WellSky will manage skilled home health and post-acute facility services.

You can continue to submit requests using one of these methods:

- Call the toll-free vendor service line at **888-258-3864**.
- Submit requests through Availity by selecting the appropriate request type. Based on the member's plan, Availity will route the request to the correct vendor for authorization.
- Fax home health services requests to tango at **877-612-7066**.
- Fax post-acute facility requests to WellSky at **877-673-8784**.

Quality Corner

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

Reducing Avoidable ER Visits and Hospitalizations

Many unnecessary ER visits and hospital stays happen because patients can't get timely care, don't have enough support managing chronic conditions or face challenges like transportation or food insecurity. Primary care teams can help prevent this by improving access, identifying risk early and guiding patients to the right kind of care.

Primary care plays a key role in keeping patients healthy and out of the ER. The strategies below show practical ways clinics can reduce avoidable ER visits and hospitalizations while improving patient outcomes and experience.

- **Educate patients about when to use the ER.** Clear guidance on when emergency care is needed—and when it isn't—can reduce repeat ER visits for minor issues. Patient education and navigation programs have shown large drops in non-urgent ER use.
- **Expand telehealth, same-day access and rapid triage.** Quick-access virtual or same-day visits help address symptoms early.
- **Focus on high-risk patients.** Identify patients who frequently use the ER or have complex conditions. Proactive outreach—like care manager check-ins, medication reviews, self-care plans and clear next steps when symptoms worsen—can prevent crises.
- **Address social needs that affect health.** Issues like housing instability, food access and transportation barriers contribute to avoidable ER use. Screening for these needs and connecting patients to community resources can help prevent emergencies.
- **Promote alternatives to the ER for non-emergency issues.** Urgent care centers and after-hours options are usually faster and less costly than the ER. They can be a better choice for many conditions.
- **Strengthen prevention and chronic care.** Regular follow-up with a primary care provider is linked to fewer ER visits and hospitalizations. Preventive services like vaccines and strong chronic disease management reduce the risk of acute flare-ups.
- **Improve post-hospital follow-up.** Scheduling a follow-up visit within seven days of discharge, especially after high-risk admissions, can significantly reduce readmissions.

Together, these strategies help patients get care earlier, reduce strain on ERs and improve overall community health. Consider starting with one or two high-impact changes, like same-day access, and track ER visits and hospitalizations over time.

Treating Patients With Low Back Pain

Low back pain (LBP) is a common reason for acute care visits. For patients with uncomplicated acute LBP, routine lumbar imaging rarely changes treatment or improves outcomes and can lead to unnecessary follow-up.

The LBP measure evaluates the percentage of patients ages 18-75 with uncomplicated LBP who don't receive lumbar X-ray, CT or MRI within 28 days of diagnosis.

When Not to Image (First 28 Days)

For uncomplicated acute LBP, avoid routine imaging during the first 28 days because:

- It rarely changes management or improves outcomes in the absence of red flags.
- It exposes patients to unnecessary radiation and incidental findings, which can drive low-value follow-up care.

Focus instead on conservative management and setting expectations for recovery.

When Imaging is Appropriate

Order lumbar imaging only when symptoms or history suggest serious pathology. The clinical concern should be specific and clearly documented. Common red flags include:

Malignancy

- History of cancer, unexplained weight loss or lack of improvement as expected
- Example ICD-10 codes: C34.10, C25.1

Fracture risk

- Significant trauma; minor trauma in older adults; known osteoporosis/fragility fracture; chronic steroid use
- Example ICD-10 codes: G89.11, J0897, M48.40XD

Severe/progressive neuro deficit

- Progressive weakness, objective deficit or cauda equina signs
- Example ICD-10 codes: G83.4, R26.2, M15.062

Infection

- Fever/systemic signs, IV drug use or recent procedure
- Example ICD-10 codes: F11.10, M46.25, F15.13

Immunocompromised

- HIV, transplant or other major immunosuppression
- Example ICD-10 codes: B20, Z21, S2152

Complex spine history

- Prior lumbar surgery or known structural disease with new/worsening symptoms
- Example ICD-10 codes: S2348, S2350

Coding is Key

When imaging is warranted, document the clinical rationale and make sure it's captured on the encounter, so the record reflects medical necessity and supports accurate quality reporting.

Pharmacy

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

Upcoming Changes to NEXPLANON® Administration

The FDA required NEXPLANON Risk Evaluation and Mitigation Strategy (REMS) has recently been updated. These changes affect both health care providers and pharmacies, and some resources now require certification.

What to know:

- NEXPLANON has extended the approved product usage timeframe to five years (previously three).
- REMS training is now required for clinicians who insert or remove the device.
- Clinicians must complete training by **Aug. 23, 2026**, to continue implanting NEXPLANON.

For more details, including provider guides, enrollment forms, adverse-event documentation forms and knowledge assessments, visit **nexplanonrems.com**.

Mid-Year Preferred Formulary Changes Effective July 1

Effective **July 1, 2026**, we'll be making a few changes to the Preferred Formulary. These changes include:

- Removing certain drugs
- Adding quantity limits to certain drugs
- Adding new prior authorization requirements to certain drugs

You can find the full list of changes on **bcbst.com/pharmacy**. Please check the mid-year **What's Changing** document for more information.

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 **800-468-9698** for BlueCare, **888-325-8386** for CoverKids or **800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **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

PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Line	Phone
Commercial Service Lines	800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	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	800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	800-468-9736
TennCare*Select*	800-276-1978
CoverKids	800-924-7141
CHOICES	888-747-8955
ECF CHOICES	888-747-8955
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueCare Plus℠	800-299-1407
Seven days/week, 8 a.m. to 6 p.m. (ET)	
***Select*Community**	800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	800-676-2583
All other inquiries	800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	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 **800-924-7141**.

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