of Tennessee

NOVEMBER 2026

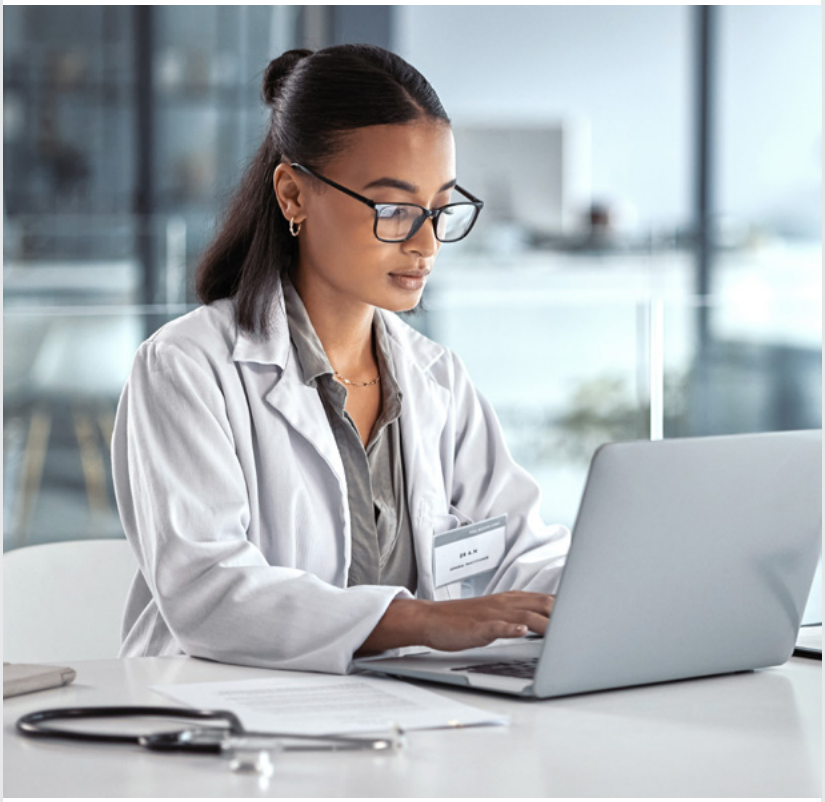
BlueAlert℠

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 up to date in your **DataSpring** (formerly CAQH) account. This helps us reach you with important communications without delay.

INSIDE THIS ISSUE

BlueCross BlueShield of Tennessee, Inc.
- Keep Your Information Current
- Global Maternity Billing Change Coming in 2027
- Final Reminder: Share Your Feedback
- More

Commercial
- BlueCard Contiguous Counties
- New Tiered Copay PPO Plan Offers Members More Cost Transparency
- Select the Correct ED Admission Category
- More

Commercial and Medicare Advantage
- New QR Code Requirement

BlueCare Tennessee
- Cancelling Transportation Services
- Catching Developmental Concerns Early
- Review Our Intellectual and Developmental Disabilities (IDD) Toolkit
- More

BlueCare Plus Tennessee and Medicare Advantage
- Care for Older Adults (COA): Close Multiple Gaps During the Annual Wellness Visit
- WellSky Enhancements Streamline Authorization Access
- One Portal for SNP Care Plans, Care Teams and Quality Measures
- Coming Soon: New Radiation Oncology Partnership with CVS Caremark

BlueCare Plus Tennessee
- Medication Reconciliation CPT® Codes
- Complete the 2026 Special Needs Plans Model of Care (MOC) Training

Medicare Advantage
- Chiropractic Services Reminder

Quality Corner
- One Visit, Multiple Opportunities: A Diabetes HEDIS® Measures Webinar
- Don't Miss This MRP Opportunity After Discharge
- THCII Episodes of Care Quarterly Report Release

Pharmacy
- TennCare Outpatient Pharmacy Benefit Coverage Change for Sunlenca and Yeztugo
- Step Therapy for Additional Medicare Part B Drugs
- 2027 Drug List Updates
- Refer to the TennCare Pharmacy Benefit Manager for Important Updates

Global Maternity Billing Change Coming in 2027

Effective **Jan. 1, 2027**, the American Medical Association (AMA) is restructuring the CPT® maternity code set. Maternity care will transition from global coding to a more granular, service-level approach across antepartum, labor management, delivery and postpartum phases. The AMA Editorial Panel has deleted 17 CPT® codes, added 12 codes, revised six codes and updated related guidelines for improved alignment between clinical work, documentation and reporting.

New BlueCross TH Modifier Billing Requirement

Effective **Jan. 1, 2027**, BlueCross will require providers to include the appropriate CPT® evaluation and management (E/M) code and the HCPCS TH modifier when billing claims for applicable antepartum and postpartum outpatient maternity services. Claims must also include an appropriate pregnancy-related ICD-10-CM diagnosis code. Missing TH modifiers or pregnancy-related diagnosis codes may delay reimbursement or result in returned charges or a rejected claim.

More Guidance Coming Soon

You can view the 2027 code set and new guidance here. The American College of Obstetricians and Gynecologists has also developed helpful information for providers, and we'll share more details in future issues of BlueAlert. Please continue to bill maternity-related services according to current coding requirements through Dec. 31, 2026.

Final Reminder: Share Your Feedback

Earlier this year, we sent out the 2026 Provider Wait Time Survey to providers in our networks. If you received the survey and haven't completed it yet, please share your feedback by **Nov. 17, 2026**. Your input helps us better understand your experience and identify ways to improve our service.

Z-Code Requirement For Genetic and Molecular Diagnostic Testing Claims Start Jan. 1, 2027

Beginning Jan. 1, 2027, providers should include Z-Codes on applicable genetic and molecular diagnostic testing claims for all lines of business.

Providers should:

- Confirm applicable tests are registered in the DEX™ Diagnostics Exchange Registry.
- Include the required CPT® code and corresponding test-specific Z-Code at claim submission.
- Refer to the Provider Administration Manual (PAM) for full details.

This requirement applies to genetic and molecular diagnostic testing claims for all lines of business submitted on or after Jan. 1, 2027.



Quarterly Network Verification Form Updates

To help keep provider directory information accurate, participating providers must complete and submit a network verification form each quarter.

We recently updated the form to make it easier to use and improve provider information.

Providers can now:

- Update your Medicaid panel size.
- Indicate whether you're accepting new patients for each participating network.
- Select the patient age ranges and sexes you accept.
- Explain how members should be reassigned to other participating providers when panel size limits are reached.

Important Information for Primary Care Providers

When Primary Care Providers (PCPs) first open the updated form, you may see a red banner stating that their maximum panel size is above the recommended limit.

Please review and update your panel size based on your provider type:

- Physicians/PCPs: Maximum panel size is 2,500 patients.
- Nurse practitioners and physician assistants: Maximum panel size is 1,500 patients.

After you enter the correct panel size, the red banner will disappear automatically.

Completing the quarterly network verification form accurately helps members find current provider information and supports appropriate provider assignments.

Get Faster Access to Remittance Information With ERA

Electronic remittance advice (ERA) gives you faster access to remittance information online, so you don't have to wait for paper statements.

With ERA, you can:

- Search and view remittance information in the **Remittance Viewer** application in the **Claims & Payments** section.
- Access remittance information directly from the **Claim Status** application while reviewing claims.
- View claims and payment information in one convenient location.

Ready to get started? **Click here** to enroll.

If you have questions, contact your **eBusiness Network Manager**.

Introducing Electronic Prior Authorization

Beginning in **January 2027**, you'll have a new way to submit and track prior authorization requests directly in your electronic health records (EHR). We're introducing **electronic prior authorizations** for all lines of business.

This new capability, powered through our partnership with **1upHealth**, is designed to make the process easier by reducing phone calls, faxes and manual requests.

What this means for your practice: fewer manual steps, less back-and-forth and a more predictable workflow for prior authorizations.

Click here to learn more about how it works and how to prepare.

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ID Card Update – Suitcase Logo Removal

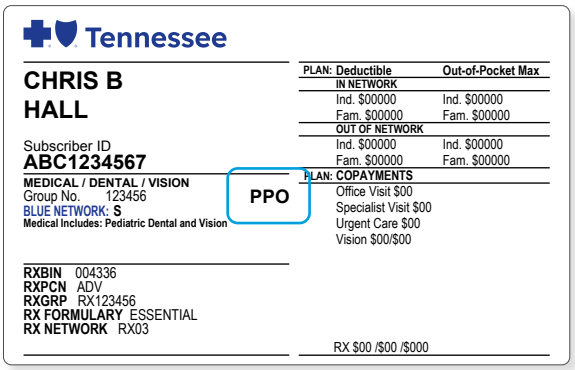
We're implementing a phased update to Member ID cards that removes the "suitcase" logo and replaces it with a product indicator (such as PPO or HMO). You may start seeing Member ID cards that feature a refreshed logo. While the look is changing, the information you use to identify and serve our members will remain familiar. Please be aware of the new design as updated cards begin circulating among patients.

This change won't require a full reissue of Member ID cards. Updated cards will be issued through normal business processes, including new enrollments, renewals and replacement card requests.

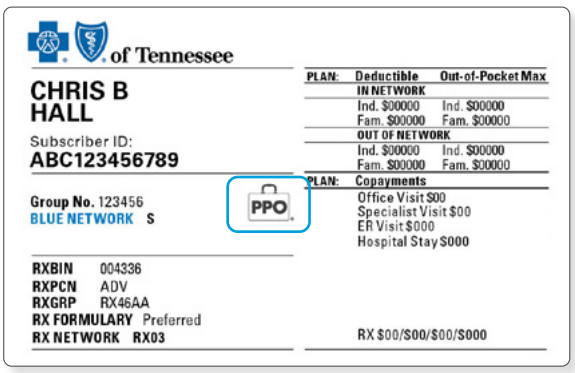
What to Expect

- Both current and updated ID card designs will remain in circulation during the transition period.
- The transition will occur gradually over the next several years.
- There's no impact to member benefits, eligibility or network access.
- Providers should continue to verify eligibility and benefits through their normal processes.

What's Changing



Updated ID Card



Current ID Card

Existing Suitcase	New Product Indicator	Applies To
PPO	**PPO**	Commercial
	TRAD	Commercial groups Quantum Health and Paramount Global
Blue HPN	**BlueHPN**	Commercial HPN groups
NetworkBlue PPO	**PPO**	Commercial groups with an alternate network
Blue Open Access POS PPO	**PPO**	Commercial groups with an alternate network
	EPO	On/off Marketplace
MA PPO MEDICARE ADVANTAGE	**MA PPO**	Medicare Advantage

* Location of the ID Card product indicator varies between each Line of Business.

Secure File Transfer Process (SFTP) Security Update: Action Needed

We're updating how data is securely sent to us. Password-based SFTP access will be replaced with Secure Shell (SSH) key authentication to better protect sensitive information.

What to Know

- Deadline: **Jan. 31, 2027**
- SSH keys will replace passwords for SFTP access.

What You Need to Do

If you use SFTP with a password:

- Create an SSH key with your IT team or vendor.
- Email your SFTP username and public key to **IO_SecureFile_Transfer@bcbst.com**.

No Action Needed If

- You already use SSH keys.
- You use the web portal for file access.

Questions?

Contact **IO_SecureFile_Transfer@bcbst.com**.

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**.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees is important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are ineligible persons, and therefore, excluded from participation in Medicare or Medicaid programs. At minimum, registry and exclusion checks must include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities, System for Award Management, and TennCare's Terminated Provider List.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the "Provider Networks – Federal Exclusion Screening Requirement" section of the **commercial** and **BlueCare Tennessee** Provider Administration Manuals.

Inquiries, Reconsiderations and Appeals Must Be Submitted in Availity

Effective **April 1, 2026**, all providers must 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 submitted through Availity.
  - You must still enter the reason for your request in the appropriate Availity field.
  - Additionally, if you received a request to submit medical records, please follow the instructions included in the notification.
- 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. It also doesn't apply to Utilization Management denials.

**Out-of-network providers who wish to submit an inquiry, reconsideration or appeal for review must still submit through Availity.

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 2027. After that, CareCentrix will begin reviewing and approving prior authorization requests for all networks. That process will start either in Availity or the DME Navigator portal. We'll share more information about that process once we have an implementation date for this transition.

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

Commercial

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



BlueCard Contiguous Counties

Some Blue Cross Blue Shield (BCBS) plans have agreements with providers located in counties that border another BCBS plan's service area.

In some cases, providers in these counties may be able to submit claims directly to a member's BCBS plan. Whether a claim can be filed this way depends on:

- The member's BCBS plan
- Provider location
- Whether the provider has a contiguous area agreement
- Where the member received services

If a contiguous area agreement is in place, claims for local members may be submitted directly to the appropriate control/home plan. For more information, review the BlueCard Provider Manual under the Resources tab in Availity.

New Tiered Copay PPO Plan Offers Members More Cost Transparency

We're introducing Tiered Copay PPO, a new commercial health plan available to large group and self-funded employer customers. Built on Networks P and S, the plan uses two in-network provider tiers across select specialties and includes out-of-state coverage through BlueCard PPO.

Members can continue seeing any in-network provider, but they'll pay lower office visit copays when they choose a Tier 1 provider. Other covered in-network services have fixed copays and no in-network deductibles or coinsurance

How to Identify Members Enrolled in Tiered Copay PPO

You can identify Tiered Copay PPO members by checking their Member ID card. The card includes a tiered office visit benefit display showing two office visit copay amounts. The first amount shown represents the Tier 1 office visit copay. You should continue to verify benefits through Availity or BlueExchange before collecting member cost share.

Where to Find More Information

You can confirm your tier designation through the provider referral directory: Provider Tier Network P or Provider Tier Network S. You can also find this information in Availity and BlueExchange. If you have questions about your tier designation or how tiers are determined, you can find the Tiered Methodology Manual and Frequently Asked Questions documents on Availity. If you have more questions, please contact your Provider Network Manager.

Select the Correct ED Admission Category

When you submit an acute inpatient admission request in Cohere, be sure to select the correct admission category if the member entered the hospital through the emergency department (ED). Don't use ED categories for direct admissions from a provider's office.

Choosing the right category in Cohere may help lead to immediate approvals when the member meets all clinical requirements. Select **Psychiatric Emergency (ED Admission)** for behavioral health admissions. Select **Medical Emergency (ED Admission)** for medical/surgical admissions.

Benefits of selecting the correct category:

Receive authorization decisions faster.

- Reduce administrative work.
- Confirm approval status sooner.
- Improve efficiency for you and your patients.

By selecting the correct ED admission category, you help us review requests more quickly and process authorizations as efficiently as possible.

Alacura Air Ambulance Agreement Ends Nov. 1, 2026

Effective **Nov. 1, 2026**, our agreement with Alacura Air Ambulance will end.

This change doesn't affect our prior authorization requirements for non-emergent air ambulance transports, including interfacility transfers.

Prior Authorization Requirements

Prior authorization is required for all non-emergent air ambulance transports, unless the member's benefit plan states otherwise.

Providers should get prior authorization before arranging transport. If a required authorization isn't received, the claim may be denied based on the member's benefit plan.

Coverage Requirements

Note: Coverage requirements for self-funded plans may vary. Verify benefits before scheduling non-emergent services.

Air ambulance services may be covered when they're medically necessary and the member's condition requires transportation that can't be provided safely by ground ambulance.

Covered services may include:

- Transport from the scene of an accident or medical emergency when the member requires rapid transport.
- Interfacility transfers when the needed treatment isn't available at the sending facility and the member must be transported to the nearest appropriate facility that can provide the required care.

No Surprises Act Protections

Federal No Surprises Act protections continue to apply to covered air ambulance services.

Members generally receive in-network cost-sharing protections and can't be balance billed for protected services, as required by applicable state and federal law.

These protections will remain in place after the Alacura agreement ends.

Before Arranging a Non-Emergent Air Ambulance Transport

Providers should:

- Verify member eligibility and benefits.
- Obtain required prior authorization.
- Confirm medical necessity.
- Verify the destination is the nearest appropriate facility that can provide the required care.

Questions

If you have questions about coverage or prior authorization requirements, contact Provider Services or refer to the Online Help resources available through Availity.

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 **Documents & Forms** page on **provider.bcbst.com**. Updates are located under **Code Edits/Code Updates** in the **News & Updates** 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**.

Commercial and Medicare Advantage

This information applies to all our commercial networks and Medicare Advantage.

New QR Code Requirement

Effective **July 31, 2026**, all exported Provider Assessment Forms (PAF) and Common Placement Assessment Forms (CPAF) include a required QR code on every page for Quality Care Rewards application uploads. Forms submitted after this date with missing QR codes will be rejected.

BlueCare Tennessee

This information applies to BlueCare℠, TennCareSelect and CoverKids plans unless specifically identified below.

Cancelling Transportation Services

Please remind your patients to contact Verida if they need to cancel or reschedule transportation. This helps reduce no-show appointments and keeps transportation available and accessible to all members.

Your patients can cancel or reschedule their ride by calling Verida's Call Center at the number for their health plan:

- BlueCare – **855-735-4660**
- TennCare*Select* – **866-473-7565**

Note: This article doesn't apply to CoverKids.



Catching Developmental Concerns Early

Taking a comprehensive developmental history and performing developmental screenings are key components of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams. Catching developmental concerns early allows children to begin interventional services as soon as possible.

In addition to regular hearing and vision assessments, screening recommendations for healthy development include:

- Developmental screenings at ages 9, 18 and 30 months
- Autism spectrum disorder screenings at ages 18 and 24 months
- Behavioral/social and emotional screenings at each wellness exam, from the newborn visit to age 21 years

When scheduling EPSDT visits, consider letting parents and guardians know if their child will be getting a developmental screening at their upcoming visit and discussing the importance of these services.

We cover well-care exams on the same **schedule** recommended by the American Academy of Pediatrics. For more information about covered EPSDT services and screening recommendations, review our **EPSDT Partners in Prevention booklet**.

Note: This article doesn't apply to CoverKids.

Review Our Intellectual and Developmental Disabilities (IDD) Toolkit

We've developed an online IDD Resource Toolkit for BlueCare Tennessee members. It contains helpful information to guide members and their families through an IDD diagnosis and connect them to resources and the IDD community.

Within the toolkit, you'll find links to organizations that offer support for people with disabilities. You'll also learn more about benefits and tools that may make it easier for members with IDD to access care and stay healthy, including:

- Free rides to health visits
- Our 24/7 Nurseline
- Dental care
- Our care team

EPSDT exams

Children and teens diagnosed with an IDD or who get Supplemental Security Income often see specialists and their primary care providers frequently, but they still need yearly preventive care. EPSDT checkups are an essential part of maintaining the health and well-being of all children and teens.



Accurate Gestational Age Coding Improves Maternal Health Reporting

When billing for pregnancy, labor and delivery, or postpartum care, include the appropriate gestational age diagnosis code (ICD-10-CM Z3A) when supported by clinical documentation.

Z3A codes identify the week of pregnancy and help improve maternal and infant health reporting.

Best practices:

- Review your coding and billing processes.
- Include the appropriate Z3A code on maternity-related claims.

Using the correct gestational age code helps ensure birth outcomes and quality measures are reported accurately.

Please review your coding and billing workflows to ensure the appropriate gestational age diagnosis code is included on maternity-related claims.

Gestational Diabetes: Help Patients Understand Their Risk

November is American Diabetes Awareness Month. Use this opportunity to talk with pregnant patients about gestational diabetes, which often has no symptoms.

Encourage patients to lower their risk by:

- Maintaining a healthy weight before pregnancy
- Gaining a healthy amount of weight during pregnancy
- Staying physically active
- Eating a healthy diet.

Talk with your patients about their risk and support healthy habits during and after pregnancy. Gestational diabetes can increase the risk of developing type 2 diabetes later in life.

PAM Update: Member Access to Care Standards

The Division of TennCare has updated two Member Access to Care Standards. These updates were part of the TennCare Attachment III contract amendments and took effect **July 1, 2026**:

- **Routine Adult Physical Examination:** Appointment availability within **15 business days** (replaces three weeks)
- **Specialty Care for Adults and Children:** Appointment availability within **21 calendar days** (replaces 30 calendar days)

Please make sure your scheduling practices align with these revised standards. We're updating the **BlueCare Tennessee PAM** for quarter one 2027 with this information.

Place of Service Billing Reminder for Urgent Care Providers

When billing urgent care claims, use place of service (POS) 20 instead of POS 11. Using POS 11 may cause an unnecessary change to the member's primary care provider, which could lead to confusion and delays in future primary care. Using the correct POS can also save you time.

BESMART Program Updates

Behavioral health providers participating in TennCare's Buprenorphine Enhanced Medication Assisted Recovery and Treatment (BESMART) Program should be aware of recent program updates from TennCare.

As of **Aug. 1, 2026**, TennCare updated the BESMART program description to include new standards and requirements for BESMART services and phases of treatment. The update also separates the induction and stabilization phases of treatment and assigns distinct billing codes for each phase. Reimbursement rates aren't changing as part of these updates.

Please review the updated program information to understand any changes that may affect billing and documentation requirements. For complete details, including the updated program description, billing codes and May 2026 webinar slides, visit the **TennCare website**.

Providers can also view new billing codes and reimbursement rates in the **Communication Viewer** in Availity.

To make sure you receive future provider communications, review and update your contact information in **Availity Payer Spaces** under the **Contact Preferences** and **Communication Viewer** tile.



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 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 Eligible Special Needs Plan (D-SNP) 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 Explanation of Benefits (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.

BlueCare Plus Tennessee and Medicare Advantage

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

Care for Older Adults (COA): Close Multiple Gaps During the Annual Wellness Visit

For BlueCare Plus Tennessee and BlueAdvantage C-SNP members, the Annual Wellness Visit (AWV) is an opportunity to complete required Care for Older Adults (COA) assessments and close multiple quality gaps during a single visit.

Complete and document the following during the AWV:

Medication Review

- 1159F – Medication List in the Medical Record
- 1160F – Medication Review Completed

Functional Status Assessment

- 1170F – Functional Status Assessment Completed



Provider Tip

Submit the applicable CPT® II codes during the visit to ensure completed assessments are reflected in quality reporting.

WellSky Enhancements Streamline Authorization Access

Recent WellSky enhancements reduce the number of steps needed to access your patients' post-acute care authorizations. When you go to the **View Existing Authorization** screen, you'll proceed directly to the member's authorization record.

These enhancements don't affect the process for requesting a new authorization.

One Portal for SNP Care Plans, Care Teams and Quality Measures

Use the Quality Care Rewards (QCR) tool in Availity to complete the Provider Assessment and Care Planning Form (PACF). You can also confirm conditions, review the member's Individualized Care Plan and support quality measures in one place.

Using the QCR can:

- Reduce paperwork and fax submissions
- Reduce follow-up calls and requests for records
- Meet quality measures, close care gaps and meet COA requirements
- Meet Special Needs Plan (SNP) Model of Care requirements and work with the Interdisciplinary Care Team (ICT)
- Improve care coordination
- Save time for providers and office staff

Review the Member's Plan of Care

The PACF includes a care plan for the member. The health plan creates it from the member's health risk assessment, care management details and needs. Review the care plan to make sure it matches your treatment plan. Update it if needed.

Your review and feedback help meet SNP Model of Care rules and support the ICT. They also help you and the health plan work together, meet the member's needs and keep the care plan current. The plan should include the member's goals, treatments and health changes.

Possible Payments

Service	Payment
G0438 First Annual Wellness Visit	$163.03
G0439 Follow-Up Annual Wellness Visit	$109.98
99366-99368 ICT	$54
96160 Complete the PACF	$155

Important: You can use information from an Annual Wellness Visit completed before you receive the PACF.

Complete Key Tasks in One Place

When possible, use Availity/QCR to complete the PACF, confirm conditions and review the care plan. This process can help meet quality and SNP rules, improve care, reduce office work and give you more time with patients.



Confirm the care plan to show that you reviewed it. Upload any records that can help the care team work together and find other care gaps.

Coming Soon: New Radiation Oncology Partnership with CVS Caremark

Soon we'll be partnering with CVS Caremark Radiation Oncology to help manage radiation treatment services for members with cancer. Together, we'll work to improve care, support treatment decisions based on proven medical guidelines, and make the care experience easier for members.

How CVS Caremark Radiation Oncology Can Help

CVS Caremark Radiation Oncology will provide support for:

- Radiation treatment services and care management
- Prior authorization reviews
- Treatment plans that follow nationally recognized medical guidelines
- Care coordination and member support

What This Partnership Means

We'll work together to:

- Make prior authorization reviews more efficient.
- Support coordinated, evidence-based care.
- Strengthen collaboration with providers.
- Help ensure members receive the right care at the right time.

Important Submission Information

- Continue submitting medical radiation treatment requests to us through your current process.
- Submit oncology-related requests to CVS Caremark Radiation Oncology.
- Online authorizations are available through single sign-on.

Phone Numbers

- BlueCare Plus Tennessee: **800-299-1407**
- Medicare Advantage: **888-258-3864**

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BlueCare Plus Tennessee

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

Medication Reconciliation CPT® Codes

Please bill CPT® II code 1111F when medication reconciliation is completed following discharge. This will reduce future medical record requests and support care gap closure. When applicable, you can also bill TCM codes 99495 and 99496 for eligible post-discharge services. Please include documentation of the discharge summary, medication reconciliation, follow-up visits and updated medication lists to support coordinated patient care.

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**.

Medicare Advantage

This information applies to our Medicare Advantage plans unless specifically identified below.

Chiropractic Services Reminder

We cover hands-on spinal manipulation to treat symptomatic subluxation when the service is medically necessary. For Medicare Advantage patients, we generally don't cover related services, such as X-rays, exams or therapies. We also don't cover maintenance care.

When you submit a prior authorization request, we'll usually approve up to eight visits within 90 days. If your patient needs more visits, update the original request. Include information showing why more treatment is medically necessary and how the patient is expected to recover or improve.

Quality Corner

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



One Visit, Multiple Opportunities: A Diabetes HEDIS® Measures Webinar

November is National Diabetes Awareness Month, so we're hosting an educational webinar for providers in our quality programs on Nov. 10 from 12:30-1 p.m. ET. The event, titled "One Visit, Multiple Opportunities," will share an overview of the diabetes-related quality measures and tips for meeting multiple measure requirements during one visit.

Registration is required. Please sign up **here**.

Don't Miss This MRP Opportunity After Discharge

Medication Reconciliation Post-Discharge (MRP) is part of the Transition of Care (TRC) Stars Measure. To meet the measure, document patient engagement within 31 days after discharge. An encounter on the discharge date counts.

Qualifying encounters include:

- Office or home visits
- Phone visits
- Telehealth visits using audio or video
- E-visits or virtual check-ins

If the patient can't communicate, document the interaction between you and the patient's caregiver. This also meets the requirement.

And be sure to document both the engagement date and the reconciliation in the medical record. Timely follow-ups help capture the care you provide. They also support patient safety, help reduce readmissions and contribute to quality performance.

Note: This article only applies to Medicare Advantage and BlueCare Plus Tennessee.

THCII Episodes of Care Quarterly Report Release

New quarterly reports for BlueCare Episodes of Care Quarterbacks will be available on **Nov. 19, 2026**. If you're having trouble accessing your quarterly report, please call **423-535-5717**, **option 2**, or email **eBusiness_Service@bcbst.com**.

Pharmacy

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

Step Therapy for Additional Medicare Part B Drugs

As of **Nov. 1, 2026**, BlueAdvantage and BlueCare Plus have implemented step therapy for additional Part B drugs. This will only affect members who are new to therapy. Prior authorization and step therapy follows CMS regulations and will be required for the following Part B drugs: Ennumo, Nufymco, Omlyclo, Ponlimsi, and Ranluspec. You can find our Part B Step Therapy guide **here**.

Please reach out to the Provider Service Team with any questions.

TennCare Outpatient Pharmacy Benefit Coverage Change for Sunlenca and Yeztugo

Effective Nov. 2, 2026, the following products will no longer be covered under the TennCare pharmacy outpatient benefit. Coverage for these medications will transition to the medical benefit for TennCare members.

- Sunlenca (HIV capsid inhibitor) oral tablets will be removed from the PDL.
- Yeztugo and Sunlenca (HIV capsid inhibitors) oral tablets/injectables will be covered under the medical benefit.

These drugs are lenacapavir-containing products with distinct indications that require close clinical oversight, adherence monitoring and coordinated care.

- Yeztugo is indicated for HIV-1 pre-exposure prophylaxis (PrEP) in adults and adolescents (≥ 35 kg) at risk of HIV-1 infection. Patients must be HIV-1 negative before starting and throughout treatment.
- Sunlenca is indicated, in combination with other antiretroviral agents, for heavily treatment-experienced adults with multi-drug-resistant HIV-1 if their current regimen is failing.



Transitioning coverage to the medical benefit supports enhanced patient safety, ensures appropriate clinical monitoring, and aligns with the level of oversight needed for these therapies. For coverage and billing details, refer to the patient's specific Managed Care Organization.



2027 Drug List Updates

We review our drug lists each year to help ensure medications remain safe, effective and affordable for our members. While many updates take effect at the beginning of the year, changes can happen throughout the year as the market evolves.

Drug list updates may occur when:

- New drugs become available after FDA approval.
- The FDA removes drugs from the market.
- New generic options become available.

We encourage providers to review the 2027 drug lists and recent updates to help support treatment planning and member conversations.

View 2027 drug lists and changes:

- **Commercial and Marketplace**
- **Medicare**
- **BlueCare Plus (Medicare with Medicaid)**

Staying up to date on drug list changes can help reduce disruptions and ensure members have access to covered treatment options.

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.

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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
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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-Friday, 8 a.m. to 6 p.m. ET	
Verida	423-893-8282

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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