NOTICE OF PROVIDER HANDBOOK CHANGES

Date: May 1, 2025

BlueCross BlueShield of Vermont
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The Provider Handbook has been updated with the following:

Summary:	Update to Section 6 Member Liabilities – How to Locate Information and When to Bill Members under "Waivers (Informed consent)"
Explanation:	Added numbers (see red font below) to further define each term: ***Waivers (Informed consent)***: Services or items provided by a contracted/network provider that are considered by Blue Cross VT to be (terms are defined in the member's certificate of coverage) (1) investigational, (2) experimental, (3) not medically necessary, (4) non-covered over $500 (billed charges), or (5) Durable Medical Equipment "upgrades" may be billed to the patient if the following steps occur:
Effective Date:	N/A. This is not a change but rather a clarification, which had not been present.
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Update to Section 4 Prior Approval under "Prior Approval"
Explanation:	Updated the information to reflect correct medical policy. Changes in red font: ○ **Dental** prior approval for (1) Health Exchange pediatric members or (2) members of an administrative services only (ASO) whose employer group has purchased dental coverage through Blue Cross VT and are eligible through our medical policy "Dental Services Pediatric (Qualified Health Plans and Applicable Plans"). Located on this link: www.bluecrossvt.org/providers/provider-policies under the Vermont Medical Policies link. These prior approvals are reviewed by CBA Blue. See "Dental Care" in Section 6 for more details.
Effective Date:	N/A. This is an annual maintenance item, verifying links
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Update to Section 6.7F Dental Care
Explanation:	Pulled eligible services and contract requirements into one area instead of separate as information repeated. Updated the information to reflect correct medical policy.
Effective Date:	N/A. This is an annual maintenance item, verifying links
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Update to Section 7 The BlueCard® Program under "Appeals"
Explanation:	Fixed the link of where to locate the BlueCard appeal form and added reminders that are on the BlueCard appeals form. Updates in red font: Appeals for all BlueCard® claims are handled through Blue Cross VT. We coordinate the appeal process with the member's Blue Plan. There is a specific form for BlueCard® appeals on our provider website under Provider Forms & Resources, on the Claim Forms and Information link under BlueCard Appeal Form, that must be completed and sent with all BlueCard® appeals. Reminders: • A BlueCard appeal form should only be used when there is a confirmed denial of benefits • Timely filing denials are not appealable and CANNOT be submitted on an appeal form. ○ If you would like timely filing reviewed – attach documentation supporting timely filing to a payment inquiry form and send by email to bluecard@bcbsvt.com • Some Blue Plans may require members to sign an additional form specific to their Plan before they will start an appeal process.
Effective Date:	N/A. This is an annual maintenance item, verifying links. The additional information has been on the BlueCard Appeal form.
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 1.6 Credentialing of Providers, added new information on Locum Tenens Provisional Credentialing
Explanation:	**Provisional Credentialing – only applies to Locum Tenens** Effective with enrollment date July 1, 2025, forward, all locum tenens must complete a provisional credentialing process. Until the provisional credentialing process is complete and the locum tenen is approved, they are not eligible to render care to any Blue Cross and Blue Shield member (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage). If they do and claims are submitted, the claims will deny as a provider liability. Provisional credentialing can take up to 5 business days to complete, if all required information is submitted and current and there are no concerns with the provisional credentialing findings. If there are issues with the provisional credentialing findings, the time frame to complete the process will vary depending on outside factors. Provisional credentialing cannot be approved retroactively. The locum tenen's effective date for inclusion in our networks will be as of the approval date of the provisional credentialing. You will receive a notice that advises when the provider is approved and effective to start to provide care to Blue Cross and Blue Shield members. If the PECF form indicates the locum tenen will be active more than 60 days, in addition to the provisional credentialing, we will also start the full credentialing process so there will be no interruption of the locum tenens network status.

Effective Date:	July 1, 2025
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 1.5 Enrollment of Providers under "Enrollment and Credentialing Requirements added information on Locum Tenens
Explanation:	See red font below for the additional information: To enroll, the group or individual must hold a contract with Blue Cross VT/ TVHP. Groups must enroll and credential individual providers who are associated with the group. **Notes:** • Providers joining existing, contracted groups or individual providers entering into a contract with Blue Cross VT are **not** eligible to render services to any Blue Cross VT/TVHP (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage) until they are fully enrolled and approved by the credentialing committee. ○ Note: Effective July 1, 2025, Locum Tenens must complete a provisional credentialing process before they are eligible to render services to any Blue Cross VT/TVHP (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage) members. • Providers enrolling with Blue Cross VT need to make sure their National Plan and Provider Enumeration System (NPPES) file is up to date—practice location(s), taxonomy, phone number, etc. NPPES is located at: https://nppes.cms.hhs.gov/#/. Blue Cross VT and our partners use NPPES to validate provider information.
Effective Date:	July 1, 2025
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Update to Section 6.7 Claim Specific Guidelines under "Designated Agencies (Vermont)"
Explanation:	The policy for Vermont Designated Agencies went from a Quality Improvement Policy to a Payment Policy. Updates noted in red font: **Designated Agencies (Vermont)** Our Payment Policy, Vermont Designated Agency (CPP_45) provides the policy, scope, process and billing for the Designated Agencies. The policy is located on the provider portal under Policies, Provider Payment Policies.
Effective Date:	May 1, 2025
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.1 General Claim Information update to *"Not Elsewhere Classified (NEC) or Not Otherwise Classified (NOS) Codes"*
Explanation:	Retitled and updated information ***Unlisted Procedures, Services or Supply Codes:*** See details in Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes".
Effective Date:	N/A no change in information just updates to reference.
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.7 Claim Specific Guidelines
Explanation:	Removed Not Elsewhere Classified (NEC) or Not Otherwise Classified (NOS) language replaced with below and instructions now included on how to have a review. **Unlisted Procedures, Services or Supply Codes** Providers should always bill a defined procedure, service or supply code when one is available. If a defined code is not available, services can be billed using the unlisted procedure, service or supply code (codes ending in "XXX99"). However, the claim must (1) be submitted on paper (until the time we are able to accept electronically) with (2) the office and/or operative notes (medical notes) and (3) include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. When a claim is received with a service line for an unlisted code, and the claim does not have both a written description of the service clearly visible and medical notes, the service line is denied as "*Plan Procedures Not Followed*" with a claim adjustment reason code of CO95. The provider is liable for this denial. This service cannot be billed to the member (even with a secured waiver) and cannot be appealed. A provider can submit a request for review within a reasonable time, not to exceed 60 calendar days from the original date of processing with the CO95 denial reason. Review requests submitted beyond 60 days from the original processing with the CO95 denial will not be accepted. To request a review, use one of the following methods: • Resubmit a corrected paper claim including a copy of the claim, a written description of the service clearly visible and medical notes • Email: utilizationmanagement@bcbsvt.com subject line: Unlisted Code Review • Fax: (866) 387-7914 Attn: Utilization Management; Unlisted Code Review • Mailing: BCBSVT, Attn: Utilization Management, Unlisted Code Review, PO BOX 186, Montpelier, VT 05601 Regardless of the method of submission, the request must include a (1) copy of the claim, or the Blue Cross VT claim number, with the (2) office and/or operative notes (medical notes) and include a (3) written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible

	and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. Note: The resubmission must include ALL required information again, even if parts were previously submitted. Note: if the review results in a denial and you are not in agreement with the decision rendered, the next step is to appeal. See details in Section 6 Member Liabilities *"Complaint and Grievance Process".*
Effective Date:	N/A update to information and added details about how to request a review.
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6.3 Paper Claim Submission under *"Submitting Attachments with Claims"*
Explanation:	Update language: • Unlisted Procedures, Services or Supply Codes must be submitted with office and/or operative notes (medical notes) and include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. See Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes" for full details.
Effective Date:	N/A no change in information just updates to language
Link to Policy/ Manual:	www.bluecrossvt.org/documents/provider-handbook

Summary:	Section 6 Member Liabilities under *"Complaint and Grievance Process"*
Explanation:	Updates below in red font: ***Provider-on-Behalf-of-Member Appeal Process***: An appeal may only be filed by a provider on behalf of a member when there has been a denial of benefit-related services for reasons such as: non-covered services pursuant to the Member Certificate; services are not medically necessary or investigational; lack of eligibility; reduction of **benefits** (not a claim editing reduction); or unlisted procedure, service or supply codes that have been through a review and denied. Before a provider-on-behalf-of member appeal is submitted, we recommend you contact our customer service team, as most issues can be resolved without an appeal. If you proceed with an appeal, there are three levels to the Provider-on-Behalf-of-Member Appeal process. **Note:** Denials for (1) lack of prior approval, (2) duplicate claims, (3) timely filing, (4) claim edits (such as inclusive, mutually exclusive), and (5) unlisted procedure, service or supply codes that have denied for a lack of description or documentation (see Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes for

	details) **cannot** be appealed, per our provider contracts. Do not file appeals for these denials.
Effective Date:	N/A added clarification on process for unlisted procedures, service or supply codes.
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