BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

December 2014

Claims Submission and the Holidays

With the holiday season is upon us, it's a good time to remind provider offices to submit claims as soon as possible to allow ample processing time. As a reminder, claims typically take 24-48 hours to appear in our processing system after submission.

Date of Death and Discharge Date Billing

Revenue Code 0224 is used to allow a Nursing Facility to bill for the date of death if a resident expires after 12 p.m. Revenue Code 0224 must be billed with one unit, using patient status code 20 and the time of discharge (in military hours) of 12 p.m. or later.

For example, if a patient expires at 2 p.m. on Jan. 16, revenue code 0224 is billed for date of service Jan. 16 with patient status code 20 and discharge hour 14.

Additionally, to ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted with a discharge status 20, 40, 41 or 42 must also include Occurrence Code 55 and the date of death. This is in addition to Occurrence Code 54.

Medicaid does not pay for Date of Discharge in a Nursing Facility except in this circumstance.

Bed Hold/Leave of Absence Days

Facilities at 85 percent occupancy or more are eligible to claim bed hold/leave of absence (LOA) days in certain situations.

The billing codes are as follows:

Revenue Code	Type of Bill	Description	Comment
185*	066x	LOA	Nursing Home - Hospital bed hold for ICF only
183*	066x	LOA	Therapeutic Leave - Overnight home visits for ICF only
189	066x/ 021x	Other LOA	Other - **Non-covered** day – ICF/SNF

*LOA for both hospital and therapeutic leave allows for a total of 10 paid days per fiscal year to use however the patient chooses.

Critical Incident Reporting Mandatory Timeframes

Following are critical incident mandatory reporting timeframes for BlueCare Tennessee CHOICES Home and Community Based (HCBS) services:

- A 24-hour verbal report is required to BlueCare Tennessee at 1-888-747-8955 followed up by a written report within 48 hours of initial discovery.
- Immediate reporting to Adult Protective Services (APS) for abuse, neglect and financial

*Sandata is an independent company that does not provide BlueCare Tennessee branded products and services. Sandata is solely responsible for the services they provide.

exploitation* at 1-888-277-8366, or by fax at 1-866-294-3961.

- Immediate reporting to BlueCare Tennessee for physical or sexual abuse or unexpected death at 1-888-747-8955. This phone number rolls to Nurseline after hours and on weekends.
- Immediate removal of the worker from interaction with ALL TennCare members for the duration of the investigation.
- A 20-day written follow-up report via email at CHOICES_Quality_GM@bcbst.com or CHOICESQuality@bcbst.com, or by fax at (615) 565-1923 or 1-855-292-3715.

*Financial exploitation includes any funds for which a government source cannot be ruled out.

The Deficit Reduction Act (DRA) of 2005

The Deficit Reduction Act (DRA) of 2005 is a piece of legislation passed by Congress that included provisions impacting Federal Health Care Programs and became effective Jan. 1, 2007. This includes any plan that provides health benefits which are funded by the U.S. Government, or any state health care programs (i.e., BlueCare Tennessee) defined under section 1320a-7 (h). The DRA provides States with much of the flexibility they have been seeking over the years to make significant reforms to their Medicaid Programs. States can expand access to affordable mainstream coverage, promote personal responsibility for health and accessing health care, and improve quality and coordination of care. As a BlueCare Tennessee provider, you will need to incorporate policies and procedures as detailed in the DRA of 2005, which include information regarding the False Claim Act and detecting and preventing fraud, waste and abuse.

BlueCare Tennessee cooperates with all state and federal agencies in the investigation of fraud and abuse. As a condition of receiving any amount of payment, providers shall comply with Section 2.20 of the Contractor Risk Agreement or the TennCare*Select* Agreement, as applicable. Other documents that providers shall comply with include the Federal False Claims Act, State Laws and the Tennessee Medicaid False Claims Act that pertain to civil or criminal penalties for making false claims and statements to the Government or its agencies, and the right of employees to be protected from retaliation as whistleblowers.

Please make sure that as a provider you have read and understood the Fraud and Abuse Section and the standards and ethical guidelines outlined in the Code of Conduct in the BlueCare Tennessee Provider Administration Manual which includes: The Deficit Reduction Act (DRA) of 2005; False Claims Act (Title 31, Section 3729); BlueCross BlueShield of Tennessee Code of Conduct; BlueCross BlueShield of Tennessee Fraud and Abuse Hotline; and Bureau of TennCare Fraud website and Hotline.

The complete BlueCross BlueShield of Tennessee Code of Conduct may be found at: http://www.bcbst.com/about/company_profile/code-of-conduct.

Providers shall have written documentation that they have educated their employees about these laws, including the whistleblower protection and how to report suspected fraud and abuse. Reportable fraud and abuse includes suspected fraud and abuse in the administration of the TennCare program, Provider fraud and abuse, and Member fraud and abuse. Any suspected fraud and abuse must be reported to the Tennessee Bureau of Investigation Medicaid Fraud Control Unit and the Office of Inspector General. To report any suspected fraudulent activity, please do any of the following:

- Call BlueCross BlueShield of Tennessee's Fraud and Abuse Hotline at 1-888-343-4221
- Go online and report your findings at http://www.bcbst.com/fraud/index.page
- Call the Bureau of TennCare from anywhere in Tennessee at 1-800-433-3982
- Complete an online form at http://www.tn.gov/tnoig/ReportTennCareFraud.shtml or download a form to mail or fax to the State of Tennessee.

Providers must develop their own training materials to include the information listed above or they may use BlueCare Tennessee materials to assist their employees in educational opportunities. Providers must also sign a training attestation (obtained by their respective Provider Network Manager) stating

they have completed training with their employees. Fax the completed attestation to (423) 591-9342.

Community Based Residential Alternatives in CHOICES

Community Living Supports (CLS) is a community-based residential alternative service for seniors and adults with disabilities encompassing a continuum of support option for up to four individuals living in a home. CLS supports each resident's independence and full integration into the community, ensures each resident's choice and rights, and comports fully with standards applicable to HCBS settings delivered under Section 1915(c). This includes those requirements applicable to provider-owned or controlled homes, as applicable, except as supported by the individual's specific assessed need and set forth in the person-centered plan of care.

The person receiving CLS services is responsible for the cost of his/her room and board, and other community living expenses. Residents may be assisted in accessing housing vouchers, and family members are not prohibited from helping pay a resident's room and board expenses.

1. **CLS1** - $1,100/month; T2032 UD, U1 **OR** $36.16/day; T2033 UD, U1 for any months when an entire month of service is not provided. This level of reimbursement is for CLS services to CHOICES members who are primarily independent or who have family members and other (i.e., non-CHOICES) paid or unpaid supports.

2. **CLS2** - $100 per day; T2033 UD, U3. This level of reimbursement is for CLS services to CHOICES members who require minimal to moderate support on an ongoing basis, but can be left alone for several hours at a time and do not need overnight staff or direct support staff to live on-site for supervision purposes.

3. **CLS3** - $139 per day; T2033 UD, U4. This level of reimbursement is for CLS services to CHOICES members with higher acuity of need who are likely to require supports or supervision 24 hours per day due to the following reasons:
   - advanced dementia or significant cognitive disability that impacts the member's ability to make decisions, perform activities of daily living or instrumental activities of daily living, including behaviors which places the member or others at risk;
   - significant physical disabilities that require frequent intermittent hands-on assistance with activities of daily living including toileting, transfers, and mobility;
   - complex health conditions and compromised health status requiring medication assistance and daily nurse oversight and monitoring and/or daily skilled nursing services as needed for routine, ongoing health care tasks, such as blood sugar monitoring and management, oral suctioning, tube feeding, bowel care, etc.

Providers are licensed by the Department of Intellectual and Developmental Disabilities and are interested in contracting with BlueCare, may contact their Provider Network Manager for further details. BlueCare is currently offering single case agreements prior to the Jan. 1, 2015 implementation of this CHOICES benefit.

BlueCare Tennessee CHOICES Conduct Statewide Provider Town Hall Meetings

The BlueCare Tennessee CHOICES Provider Relations department held seven town hall meetings across the state in November. The meetings were designed to educate our Middle Region providers and refresh established providers on important CHOICES information. More than 500 providers gained additional insight through a presentation on long-term care benefits and processes for CHOICES members, details surrounding the provider agreement, critical incident reporting, credentialing and site visits, and much more. Providers received instructional packages enabling further distribution within their organization.

A reference document, the *CHOICES Claims Reference Guide,* created specifically for CHOICES providers, was also distributed to participants. This essential guide provides direction on numerous claims scenarios, and will serve as an important resource for all CHOICES provider types. Guidance for web portal submissions and Nursing Facility claims are included in the guide, along with other key processing topics.

Some of the important reminders shared during the sessions were MCO timely processing claim metrics as noted:

- *90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims are processed and paid within 14 calendar days of receipt.*
- *99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims are processed and paid within 21 calendar days of receipt.*

Providers were also reminded that effective Jan. 1, 2013, claims must be submitted within 120 days from the date of service or within 60 days from the date of the original BlueCare Tennessee rejection notice, whichever is later. This denial can be reviewed per the provider's request, with acceptable documentation, such as a copy of a 277 Error Report. The member cannot be billed when a claim has received a timely filing denial.

Additionally, providers heard about upcoming key Middle Region implementation efforts and guidelines. Following are some key facts shared:

1. One-third of the TennCare population, including CHOICES enrollees, will be reassigned to the new MCO assigned in each grand region.
2. Enrollees selected to be reassigned to a new MCO should have received two notices (Oct. 1 and Nov. 14, 2014) with instructions about the reassignment process.
3. TennCare strongly discourages Long Term Care Services and Support (LTSS) providers from attempting to influence members' decisions regarding the reassignment.
4. Members selected to reassign will be given an opportunity to opt out of the reassignment before it occurs. Also, those that do not opt out will have a 45-day period after reassignment during which they may move back to their previous MCO.
5. When members have questions, please remember to refer them to the MCO.

There were a number of topics discussed during the Provider Question and Answer segments. The Top Ten are noted below:

Question	Response
How will providers know if a BlueCare member is transitioning?	Members received notification from TennCare of their reassignments. Additionally, BlueCare will initiate end-dates for authorizations and will send notice via fax to indicate a member's reassignment.
What is the time frame to opt out of transitioning to another MCO?	Enrollees affected received letters with opt-back forms 30 days before the effective date of their reassignment. Enrollees have until Feb. 14, 2015 to "opt-back" to their original MCO by completing the enclosed form and sending to TennCare.
How may a provider become contracted with BlueCare?	Providers interested in becoming contracted within the BlueCare Network may reach out to the regionally assigned Network Manager, or may call 1-800-924-7141.
What happens when an authorization ends on Dec. 31, 2014?	Once authorizations are ended, no further services should be rendered to that member

	of the former MCO. When the member becomes reassigned to their new MCO, payment of services will be provided by the new MCO.
What will happen to provider's billing during the MCO change?	The newly assigned MCO will be responsible for making payment of services to an eligible CHOICES member.
When will authorizations change in Sandata for reassigned members?	Authorizations will start changing for reassigned members between Nov. 21 and Dec. 31, 2014. Providers will begin to receive Plan of Cares with authorization end-dates of Dec. 31, 2014, for members transitioning from BlueCare Tennessee. Members transitioning to BlueCare Tennessee will have authorization dates beginning Jan. 1, 2015.
If a member is reassigned to another MCO, and the provider is not contracted with that MCO, what happens?	Although providers are not mandated to contract with all MCO's, it is encouraged that you attempt to do so.
How will a Nursing Facility know if a member is being reassigned?	Nursing Facilities will receive notification from BlueCare Tennessee of changes for BlueCare Tennessee CHOICES members.
Will the admission date change for nursing homes with the MCO change?	No, the date that the CHOICES member is admitted to the Nursing Facility remains the same, unless the member is discharged from the Nursing Facility.
What is the role of a Care Coordinator for group 3 CHOICES member currently in Nursing Facilities during the transition?	Prior to Jan. 1, 2015, the new MCO Care Coordinators will make outreach to all reassigned CHOICES members to introduce themselves. After Jan. 1, 2015, the BlueCare Tennessee Coordinator will have primary responsibility of transitioning the group 3 member to the community if they are in the Nursing Facility.

Documents presented during the Town Hall meetings are located and available at bluecare.bcbst.com under the Provider Outreach section, CHOICES 2014 Town Hall Meeting.
BlueCare Tennessee CHOICES Provider Training 2014 Town Hall Meetings:
http://bluecare.bcbst.com/forms/CHOICES/Provider_Training_Town_Hall_Meeting.pdf

BlueCare Tennessee CHOICES Provider Claim Reference Guide:
http://bluecare.bcbst.com/forms/CHOICES/CHOICES_Claims_Reference_Guide.pdf

Electronic Claims Submission Required for all Providers

Effective Jan. 1, 2015, all network providers are required to submit claims electronically. Besides lowering administration costs and streamlining adjudication, providers will be able to view claims status online. BlueCare Tennessee CHOICES providers may register for BlueAccess℠ or, employ the use of a third party vendor to assist with submitting claims electronically, and enhance the accuracy of submissions. This electronic process also ensures that you can review remittance advices online. Further advantages to electronic claims submission include:

- Reimbursements received sooner
- Added security during submission process
- Increased efficiency

You still have time to sign up before the Jan. 1, 2015 deadline. Go to the BlueCross website at bcbst.com, click on the BlueAccess registration link and follow the first time registration guidelines. If you have any questions, please call eBusiness Solutions at (423) 535-5717 or email eBusiness_Service@bcbst.com for assistance.

You will also need to request a "Shared Secret" for all provider ID numbers that require access. Simply complete information located under the Account Management section within the BlueAccess Main Menu.

For your convenience BlueCare eBusiness regional contact information is noted below:

West TN - Debbie Angner
P: (901) 544-2285
Email: Debbie_Angner@bcbst.com

Middle TN - Faye Mangold
P: (423) 535-2750
Email: Faye_Mangold@bcbst.com

East TN - Faith Daniel
P: (423) 535-6796
Email: Faith_Daniel@bcbst.com

Service Center – Technical issues or general questions
(423) 535-5717
ebusiness_service@bcbst.com

IMPORTANT! BlueCare Tennessee CHOICES Network Provider Changes Notification Process

Contracted network providers are required to inform BlueCare Tennessee immediately as indicated below should any of the following changes occur as related to its contracted providers:

- ✓ Name changes, or acquisitions – 30 days in advance of the change
- ✓ National Provider Identifier (NPI) – 30 days in advance of the change
- ✓ Change in tax identification number (a copy of the W-9 is required) – 30 days in advance of the change
- ✓ Change in address, phone numbers, billing service and other demographic changes – 30 days in advance of the change
- ✓ Loss of or change in professional liability insurance - immediately
- ✓ Loss of or change in licensure - immediately
- ✓ Any other change that may affect a provider's status as a contracted provider – 30 days in advance of the change; examples include:
  - Any legal or governmental action initiated against the Provider, including but not limited to, an action:
    - For professional negligence
    - For a violation of law;
    - Which, if successful, would materially impair the ability of the Provider
    - Any system changes that may impact delivery of care

All changes for BlueCare Tennessee CHOICES Providers must be sent at least thirty (30) days prior to the effective date of the change to:

ChoicesProviderRelations@bcbst.com

HCBS Setting Rule Provider Self-Assessment and Transition Plans

In July, the Bureau of TennCare held statewide meetings to inform providers of the new Centers for Medicare and Medicaid Services (CMS) HCBS Setting Rule. These rules require that HCBS providers demonstrate their compliance with the HCBS Setting Rule by completing a provider self-assessment and/or demonstrate their intent to become compliant with the HCBS Setting Rule by developing a Transition Plan.

BlueCare Tennessee CHOICES or another designated reviewer should have recently contacted you to confirm your participation in the Bureau of TennCare's HCBS Setting Rule Provider Self-

Assessment and Transition Plan Training and receipt of the required HCBS Provider Self-Assessment Materials.

The Bureau of TennCare has developed a database (***Wufoo***) for you to complete and submit your Provider Self- Assessment. BlueCare Tennessee CHOICES or another designated reviewer will forward the applicable web links that should be used to complete the required assessment according to your provider type:

HCBS _Non-Residential_ Provider Self – Assessment

- Facility Based Day
- Community Based Day
- In-home Day
- Supported Employment
- Adult Day Facility

HCBS _Residential_ Provider Self- Assessment

- Assisted Care Living Facilities (ACLF)
- Adult Care Homes
- Residential Habilitation (includes Medical Residential and Community Living Supports)
- Supported Living (includes Medical Residential and Community Living Supports)
- Family Model Residential (includes Community Living Supports)

The Timeline below is the Blue Care Tennessee “preferred dates” for the Assessment completion dates (not mandated):

BlueCare Tennessee CHOICES Action Item	Timeline
Outbound Provider Telephone Call	Nov. 12 - Nov. 14, 2014
Email Provider Self – Assessment Documentation	Nov. 14, 2014
Outbound Provider Telephone Call	Nov. 18 – Nov. 21, 2014
Outbound Provider Telephone Call	Dec. 9 – Dec. 12, 2014
BlueCare Tennessee CHOICES Webinar	Dec. 16, 2014
Outbound Provider Telephone Call	Jan. 6 – Jan. 9, 2015
Outbound Provider Telephone Call	Jan. 20 – Jan. 23, 2015
Projected Submission Date/ Outbound Call	Feb. 3 – Feb. 6, 2015
Provider Self-Assessment Due Date	Feb. 13, 2015

Questions or requests for assistance should be submitted to ChoicesProviderRelations@bcbst.com.

Contact Information

BlueCare Provider Service: 1-800-468-9736

TennCare*Select*: 1-800-276-1978

Care Coordination: 1-888-747-8955

NurseLine: 1-800-262-2873

Nursing Facility Hotline: 1-866-502-0056

Sandata Client Relations (EVV):
1-877-526-0516