BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

February 2015

Billing Guidelines-Attending Physician

The following guidelines must be applied to claims submitted outside of Sandata on or after July 1, 2014.

- **Attending Providers - Consumer Direction**: These claims will continue to be submitted with the worker's assigned CD number as the Attending Provider. The ID must be within the range of CD00001 – CD99999.

- **Attending Providers with a National Provider Identifier (NPI)**: These claims will continue to be submitted with the provider's NPI as the Attending Provider. The NPI must be valid and recognized by our system.

- **Atypical Attending Providers without an NPI**: Effective July 1, 2014, these claims must be submitted with the Attending Provider's 7-digit Medicaid ID number. The Medicaid ID number must be valid and recognized by our system.

If you need assistance, please contact your Provider Network Manager or call BlueCare Provider Service at 1-800-468-9698 Monday through Friday, 8 a.m. to 6 p.m. (ET)

Reminder: Timely Filing Limits

Effective January 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. The member cannot be billed when a claim has received a timely filing denial.

Timely filing for corrected bills is 120 days from the remit date of the original claim. If a corrected bill is received more than 120 days after the remit date of the original claim submission, the corrected bill will be allowed to deny with WK3.

Ingenix Claims Editing System (iCES)

Effective March 31, 2014, BlueCare Tennessee began using the Ingenix Claims Editing System (iCES) to review claims prior to processing. iCES is a claim editing tool used to improve the accuracy of claims payment to all providers.

Since implementation, the most common iCES denials received on CHOICES claims are related to diagnosis codes. The following information will help you determine what action needs to be taken to correct any claims receiving the following denials.

x53: A manifestation code cannot be used as principal diagnosis.

Manifestation codes should not be submitted as the principal diagnosis as these codes describe a symptom of an underlying disease, not the disease itself. For example, 294.10 (Dementia in conditions classified elsewhere without behavioral disturbance) is considered a manifestation code to Alzheimer's disease. A corrected claim must be submitted with a principal diagnosis code that is not considered manifestation.

y24: Diagnosis and age conflict; x62: Admit Diagnosis Age Conflict; x70: Diagnosis – Age Conflict
These explanation codes are generated when a diagnosis code applies to a specific age range and the member's age is outside that range. For example, diagnosis code 783.41 applies to patients aged 0-17; therefore, this diagnosis code would not be appropriate for members outside that age range. A corrected claim must be submitted with a more appropriate diagnosis code.

Additional information regarding manifestation codes and age-appropriate codes can be found at the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/downloads/MCEonIPPSUserGuide.pdf

Enhanced Respiratory Care Service Update

BlueCare Tennessee (BCT) is dedicated to improve the process for requesting and approving Enhanced Respiratory Care (ERC) Services for all CHOICES members to meet our contractual agreement with the Bureau of TennCare. Nursing Facilities (NF) will begin seeing these changes in the next few weeks. These processes may affect claims processing if they are not adhered to.

When requesting chronic ventilator or ventilator weaning authorizations, the nursing facility must provide information to BCT and adhere to the following:

1. NF will send a signed attestation which attests to the licensure and availability of an enhanced respiratory care bed in the facility. This form will be provided by BCT and is to be returned within 48 hours via Fax: 1-855-273-5838.
2. For requests of chronic ventilator or frequent tracheal suctioning for CHOICES members, there must be a current and approved Pre-Admission Evaluation (PAE) in TennCare Pre-Admission Evaluation System (TPAES) with the approved services and dates of approval.
3. For requests of ventilator weaning, NF must complete the Enhanced Respiratory Care Ventilator Weaning Request Form provided by BCT. This must be returned via Fax: 423-535-7790.
4. For initial and continued authorizations the NF must send BCT supporting documentation every 30 days with an attestation.
   - Signed physician orders
   - Current Respiratory log for 30 days
   - History and Physical
   - Nursing progress notes
5. If the review of documentation by BCT indicates a change in the utilization of services for chronic ventilator services, then CHOICES will request the NF to complete Enhanced Respiratory Care Ventilator Weaning Request Form to be faxed to BCT Transition of Care via Fax: (423) 535-7790 for review by the Medical Director and authorization of ventilator weaning.
6. BCT will provide letters for approval or denial of requests.

Frequently Asked Questions and Answers CHOICES Minor Home Modifications

What Minor Home Modifications are included?
Installation of certain home mobility aids, including but not limited to: wheelchair ramps and modifications directly related to and specifically required for the construction or installation of the ramps; hand rails for interior or exterior stairs or steps; or grab bars and other devices. Minor physical adaptations to the interior of a member's place of residence that are necessary to ensure his/her health, welfare and safety, or which increase his/her mobility and accessibility within the residence, including but not limited to: widening or doorways; or, modification of bathroom facilities.

What Minor Home Modifications are excluded?
Installation of stairway lifts or elevators; adaptations which are considered to be general maintenance of

the residence; adaptations that are considered improvements to the residence; adaptations that are of general utility and not of direct medical or remedial benefit to the individual, including but not limited to: installation, repair, replacement of roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; installation or repair of driveways, sidewalks, fences, decks, and patios and adaptations that add to the total square footage of the home.

What guidelines are used for the CHOICES Minor Home Modification program?
All services and bids shall be provided in accordance with applicable State or Local Building Codes. All bids and services must comply with *the "2010 ADA* Standards for Accessible Design." (International Codes Council (IDD), and/or reference ICC/ANSI A117.1, the ICC Residential Code, ICC Plumbing Code and related Codes all of which are coordinated with ICC Building Code).

What are the cost caps or benefit limits placed on Minor Home Modifications projects?
Benefit Limit - $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime.

How long is the process of a Minor Home Modification?
All Minor Home Modifications have a 90 calendar day timeframe to get installed in the member's home from the time the member becomes CHOICES eligible or from the day the Minor Home Modification is placed on the member's Plan of Care. When a provider is awarded a Minor Home Modification, the **Provider Inquiry Specialist** will contact the provider with due date before the authorization is sent.

How are Minor Home Modifications bid requests sent to providers?
Bid requests are sent to the providers by secured email with request, specification and member's information.

When and how are bids to be returned?
All bids are to be returned in 10 days by e-mail to Home Modification Specialist and HomeModInspection_GM@bcbst.com. All bids are to have the required information as request by the Best Bid Practices Aid.

When will Minor Home Modification Bids be reviewed?
Bids will be reviewed after 10 days with the approval process and authorization proceeding after review and recommendation of bids.

How will providers be notified of authorization and scheduling of project?
The Provider Inquiry Specialist will contact provider by email and phone with authorization, scheduling and information.

Who should providers contact for questions?
Contacts depend on the type of question or problem. If questions are on Minor Home Modifications related bids and services, the contact would be the **Home Modification Specialist** assigned to the grand region (see below) or the **Provider Inquiry Specialist**. If there are questions or problems on network systems, claims or contract provisions, the contact would be the **Provider Network Manager** assigned to the region.

Contact Information:
East and Middle Grand Region Inspector
Steve Hargis
(423) 443-0736

West and Middle Grand Region Inspector
Blake White
(901) 562-3177

Statewide Provider Assistance for MHM
Tracy Lillard
(615) 565-1978

CHOICES Nursing Facility Provider Update

A memorandum was provided to providers that outlined changes to the liability insurance requirements for all participating Medicaid Nursing Facilities on Oct. 23, 2014. A reminder is noted below:

February 2015

Providers, when the CHOICES program began in 2010, the Bureau of Tennessee opted to exempt Nursing Facilities that did not possess liability insurance from this requirement to ensure the continuity of member care. This requirement is in the Contract Risk Agreement (CRA), located in section A.2.12.9.46 for your review. The exemption from this requirement was allowed through Section A.2.12.11.16 in the Contract Risk Agreement (CRA), and now the three-year time exemption period has expired.

Beginning July 1, 2015, to participate in the CHOICES program, Nursing Facilities must have adequate levels of liability insurance to protect the Managed Care Organization (MCO) and the members that you serve. Many of you are currently insured in accordance to the general and professional liability limitations and you will receive notification of your compliance. For Nursing Facilities that have not obtained the proper coverage, you have been contacted by one of the Provider Network Managers regarding this requirement and the appropriate liability amount. The following liability insurance coverage levels are what TennCare advised the MCOs and Nursing Facilities are adequate protection amounts. Although, facilities should seek counsel to determine if greater amounts are necessary.

- General and professional liability insurance at a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,0000) in aggregate; or
- Self-insurance of its professional and general liability so long as that insurance is verified by an independent auditor or actuary to be at reserve funding levels adequate to cover the operating risks to the facility.

BlueCare Tennessee will continue to contact your facility as a reminder of the July 1, 2015, deadline. Nursing Facilities that are unable to demonstrate compliance with the minimum liability protection requirements (or demonstrating sufficient self-insurance) by this date will no longer qualify to participate in the CHOICES program. Verification will be conducted during the credentialing process.

Middle Tennessee Implementation Provider Reminders (Participating and Non-Participating)

What changes took place?

TennCare transitioned from two health plans in each grand region of the state to three health plans statewide. Since Jan. 1, 2009, United Healthcare and BlueCare have operated in East and West Tennessee and UnitedHealth Care and Amerigroup have operated in Middle Tennessee. Jan. 1, 2015, UnitedHealth care, BlueCareTennessee and Amerigroup began operating statewide. This offers more options to our CHOICES members. Since three health plans are available to members, remember that some members transitioned to a new health plan to ensure even distribution of enrollment.

Date Reminders

Nov. 14, 2014:

Notices were sent to transitioning members informing them of their new health plan assignments.

Dec. 31, 2014:

Members were sent a notice reminding them of this date *to* ***request to stay*** with their current health plan. Members also received information on how to request to stay, which was included with their notice. Members continue to be enrolled in their current health plan until December 31, 2014. Members were also advised that they can only transition to their new plan or request to stay with their current plan; they cannot request to move to another plan. They will be able to choose any plan during their annual open enrollment period.

Jan. 1, 2015:

Members who were sent notices and did not request to stay with their current MCO transitioned to their new health plan. This could mean they will have to see new health care providers if you are not contracted with their MCO. If you are ***non-participating providers***, we request that you support the transition and continue services as outlined on the current Plan of Care. If you have questions, contact ChoicesProviderRelations@bcbst.com.

Feb. 14, 2015:
Members who transitioned to a new health plan have until this date to ***request to change back*** to their previous health plan. There is information on how to request to change back to their previous health plan included with their notice.

Continuity of Care for CHOICES Members

Starting Jan. 1, 2015, CHOICES members moved to their NEW MCO. Until at least Jan. 31, 2015, members will keep getting the same long-term services and supports they had. And, members can get them from the same nursing home or home care providers that they had before the reassignments.

Providers, if members selected to continue with their same provider of services, please continue to provide these services *(participating and non-participating providers).*

What happens after Jan. 31, 2015? If you are currently not contracted with BlueCare Tennessee and wish to do so, contact the Provider Relations Team at ChoicesProviderRelations@bcbst.com.

Current Contact Information is Key

We know you have a lot on your mind, most importantly making sure members get services and you get paid. It's just as important to make sure you keep your provider information updated.

Provider information is an integral part of keeping our network current. Incorrect information leaves the chance to delay a service to a member and/or the delay or denial of a payment for a service. These are just two examples of why it is important for BlueCare Tennessee CHOICES to have your most recent information for all locations including but not limited to:

- NPI (National Provider Identifier)
- TIN (Tax Identification Number)
- Disclosure of Ownership Form
- Address
- Phone/Fax/E-mail

The Provider Network Management team works to keep the most up-to-date information in the system and appreciates your assistance. If you have any information that needs to be changed or updated, please contact your Provider Network Manager by phone or e-mail. If you are unable to reach them directly, call 1-800-924-7141 or e-mail ChoicesProviderRelations@bcbst.com

Provider Network Managers

- West Grand Region – Sherry Metts (901) 544-2459
- North West / North East Middle Grand Region - Vincent Cardi (615) 565-1907
- South West / South East Middle Grand Region - Jeffrey West (615) 565-1937
- South East Grand Region - Bianca Merrell (423) 535-5900
- East / North East Grand Region Jonathan Miller 423-854-6001

Electronic Visits Verification (EVV) Reminders

If you are required to use the EVV system for your staff checking in and out and submission of claims (Adult Day Care, Attendant Care, Companion Care, Home Delivered Meals, In-Home Respite, Personal Care), see below:

- Please remember to review Imported Members (these are your newly assigned members) noted with a yellow icon as ***CM Middle***.
- Make these members active and begin creating templates.
- If there is a generic date of 1/1/1900, do not import these members.
- Member eligibility may be validated for CHOICES within EVV.

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

February 2015

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
E-mail 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

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