BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

JUNE 2016

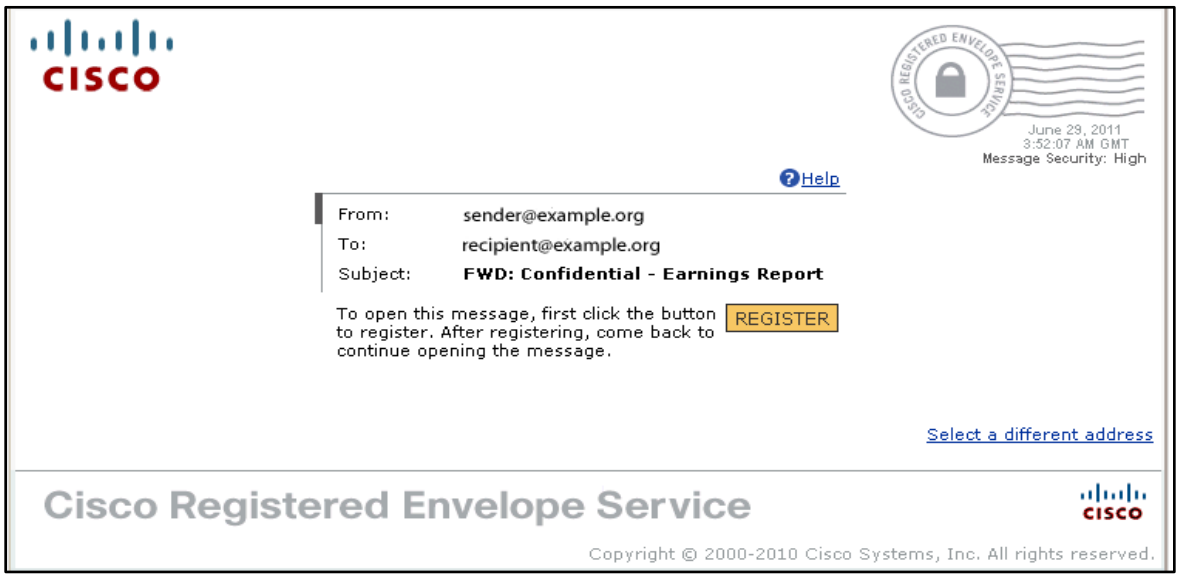
Delivery for Members' Plans of Care Changing from Fax to Secure Email

Many of our providers told us they would prefer to receive the member's Plan of Care (POC) via email rather than by fax, so we're changing our delivery method. BlueCare CHOICES will begin sending the member's (POC) via secure email. The POC includes information related to the member's care needs.

To ensure each assigned member's Plan of Care is submitted and received by the designated staff, be sure to provide your most current email address where your organization should receive the Plan of Care to ChoicesProviderRelations@bcbst.com. As a reminder, EVV is used to validate receipt of a member's POC and acknowledge provision of the services included in the plan.

How to Access Your Secure BlueCare CHOICES Emails

1. Open the attached file in a web browser and you will see a Registered Envelope (example below).



2. Click the "Register" box in the envelope to enroll with Cisco Registered Envelope Service (CRES).

After you open a Registered Envelope, you can click "Reply" to send a Secure Reply message or click "Forward" to send a Secure Forward message. When you send a Secure Reply or Secure Forward message, the recipient receives a Registered Envelope containing the encrypted message. Depending on the original sender's preferences, some features may not be available. For example, it might not be possible to send a Secure Reply or Secure Forward message.

For more information, please view Cisco's Frequently Asked Questions page.

Managing Missed and Late Visits

Managing missed and late visits is an important part of the service you provide to members and a requirement of your contract.

You will continue to receive monthly reports of your organization's performance regarding total missed and/or late visits. The organizational performance is a result of total visits per member if outside of the approved Plans of Care time and frequency of visits.

Please take time to review the *Guidance on Missed and Late Visits* and ensure you have adequate staffing, appropriate oversight for the EVV process, and remain compliant for this required component of your contract. The guidelines are also available in exhibit B of your HCBS contract.

Important Reminders:

- Providers are **required** to electronically clock in and out for approved services rendered to CHOICES members (all services applicable).
- The check-in and check-out process for workers should be timely and accurate using the GPS device. (Telephony is only to be used when a device is not available or does not work.)
- BlueCare providers using Sandata must adhere to "auto-scheduling" and refrain from manually inputting schedules.
- If your agency experiences issues with the GPS device or the approved member phone number, contact BlueCare immediately.
- When there is probability of missed visits, initiate the back-up plan as documented in the member's plan of care.
- Ensure workers have time sheet templates during visits for events of technical issues.
- If/when you encounter missed visits; accurate reason codes must always be entered in order to avoid delays in the electronic billing process.
- Avoid using the reason code **"other"** to ensure an appropriate reason for the "provider missed" visit is entered.

Providers who are regularly non-compliant with EVV management and monitoring guidelines could be placed on a corrective action plan.

Quality Monitoring for Enhanced Respiratory Care

Proper ventilator care and frequent tracheal suctioning are vital for BlueCare Tennessee members who need these enhanced respiratory care (ERC) services to live. We have a quality monitoring strategy to ensure facilities and individuals who provide ERC services properly.

Our ERC quality team meets monthly to discuss member specific cases, individual concerns and performance; reviews data analysis of specific nursing facility (NF) ERC data, including claims and utilization trends. We also monitor providers caring for members, which includes a monthly review of ERC quality data submitted by facilities to TennCare and an onsite visit by a respiratory care practitioner to review member care.

This team monitors the quality of services provided by our contracted facilities to individuals for whom services are authorized for ERC reimbursement. Such monitoring shall include, but is not limited to a monthly review of ERC quality data submitted by facilities to TENNCARE and onsite review by a respiratory care practitioner with sufficient experience to adequately monitor the quality of care provided by the facility to each of the our members.

Deficiencies are immediately reported to TennCare. If the deficiencies are serious enough to raise concerns about potential licensure rule violations, they are reported to the Tennessee Department of Health for review. We will also consider removing the provider from the BlueCare Tennessee network.

Hospitalization Reporting

When CHOICES members are hospitalized their risk for losing functional ability and health related complications increases.

If you learn that a CHOICES member is in the hospital or was recently released, please make sure you notify us the same day. After the member's hospital stay, we will evaluate the member's needs and adjust the Home and Community-Based Services (HCBS) Plan of Care as necessary.

Please report a member's hospitalization to us by phone anytime, day or night.

- Regular business hours call BlueCare CHOICES: **1-888-747-8955**
- After hours call our 24/7 Nurseline: **1-800-262-2873**

Reminders for Using GPS Devices

Providers have used GPS devices to clock-in and clock-out since last year, and we want to make sure your employees are following the guidelines. Here are a few reminders for your staff:

- Telephony is only to be used when a device is not available or does not work.
- Workers should use the same method to clock-out as they did to clock-in.
- Workers should enter the tasks they complete that day.
- Workers are required to answer the survey at the end of the shift.
- Schedules are based on authorizations. While providers no longer need to schedule appointments, they do need to ensure workers are assigned for those appointments.
- BlueCare must approve any deviation to a member's schedule.

The following are important measures pertaining to the utilization and adherence to the GPS device.

- CHOICES providers must ensure workers are properly trained and using appropriate log-in information. (Training available on the Sandata website, click here to log-in or register. Registration assistance is in the attached PDF.)
- Utilization reporting with organizational results will be provided monthly along with Missed and Late visits to convey an awareness of non-compliant providers.
- Member experience of care is critical, surveys completion is required.
- Missed visits are monitored; ensure workers clock in immediately (BlueCare will make outreach to providers when this circumstances occur for member's safety and welfare).

Your agency has a contractual obligation to use the device. Please contact your Provider Relations Representative if your table is lost or stolen or if your staff needs training.

Please contact Sandata if you experience technical difficulties, such as: error Invalid Agency ID, username and/or password, the device freezes or has fatal errors or the device is plugged in for at least 10 minutes but will not power on.

Pre-Admission Evaluation

Before admitting a CHOICES member for care at a nursing facility, the member must have a pre-admission evaluation (PAE). To satisfy the need for the inpatient care aspect of LOC, the individual must have a physical or mental condition, disability, or impairment that, as a practical matter, requires daily inpatient nursing care. The individual must be unable to self-perform needed nursing care and must have a total acuity score of at least 9 on the TennCare NF LOC acuity scale or meet at-risk level of care as described below on an ongoing basis and be determined by TennCare to not qualify for enrollment in CHOICES Group 3 based on a safety determination.

The Bureau of TennCare offers the following tips for submitting a PAE:

- Be sure to keep up with any PAEs that have an end date. All end- dated PAEs must have a new PAE submitted no later than 8 business days prior to the end date listed on the PAE in order to keep the services requested without a gap or delay. The PAE can be submitted up to 30 days prior to the end date.

(CONTINUED)

- An approved PAE is valid for 365 days unless the PAE specifies another end date. If you have submitted a PAE and there are more than 90 days between the PAE approval date and the MOPD, the PAE must be re-certified to show that the individual continues to meet the level of care represented on the initially submitted and approved PAE. Once a person is enrolled in CHOICES, LOC is verified annually through the MCO.

Revision Tip

When a technical denial is used, it should be immediately revised and resubmitted. Once you hit "Revise", you must click "Edit" in order to update incorrect or incomplete information. "If you do not hit "Revise" and then "Submit", the PAE will not be sent to TennCare for review.

If you have PAE (also known as Medical Eligibility) questions please call the LTSS Help Desk at 1-877-224-0219. LTSS handles questions regarding PAE/Medical eligibility, PAE Appeals, and TPAES help.

Critical Incident Reporting: Reporting to Adult Protective Services

Critical Incident Scenario - What Should You Do?

You are the office manager for a Home and Community Based Services provider. It's been a long week. You have exciting out-of-town plans with your family for the weekend. Friday is finally here and you are just about to leave the office at 5 p.m. when your phone rings. One of your employees reports that she witnessed a family member physically assault your client.

What are your immediate actions to ensure the health and well-being of your member and ensure your worker is protected? If you answered; contact Adult Protective Services and BlueCare CHOICES to submit a critical incident report, you are correct!

Critical incidents involving abuse, neglect or financial exploitation are to be reported to Adult Protective Services (APS) within 24 hours of discovery. (Note: the timeframe is calculated by actual clock hours, not business days) All Critical Incidents must also be reported to BlueCare CHOICES within 24 hours of discovery.

If you have any suspicion that a situation should be reported to APS, it is always best to err on the side of caution and report the allegations. Signs and symptoms of physical abuse, sexual abuse, financial exploitation, emotional (psychological) abuse and neglect may be located in the Neglect and Abuse Information section of the Provider Administration Manual.

Adult Protective Services
Phone: 1-888-277-8366
Fax: 1-866-294-3961

Staff Training

Hopefully in the previous scenario, you knew your employee could handle the situation because you've trained your staff properly. You can't wait for a critical incident to train your employees, you must be proactive.

Now is the time to consider what education has been provided to your staff to assist them in identifying signs of abuse, neglect or financial exploitation while providing care to a member.

How long has it been since you have educated your staff on when to call APS?

Does your staff feel comfortable in contacting APS when a situation arises?

In the first quarter of 2016, 10 out of the 45 Critical Incidents reported to BlueCare CHOICES involved financial exploitation, sexual abuse and/or suspected sexual abuse and suspected physical or mental abuse. By empowering your staff to identify and report allegations of these types, you will work together to help ensure the members you care for and your workers remain in a healthy, safe environment.

Top Claim Rejection and Denial Reasons

In an effort to reduce claim rejections and denials, the following supplemental information about top rejections and denials is provided to assist you in the event you encounter them. You may also contact Customer Service for additional assistance.

Rejection Reason	Additional Information
110001: Duplicate to receipt date MM/DD	The purpose of this rejection is to identify duplicate claims that have been submitted within a 45-day period, and prevent these claims from being routed to the claims area for processing. To avoid this rejection, please review your remittance advice prior to resubmitting a claim and be sure to follow corrected billing guidelines in the event a correction must be submitted.
150157: STMT FRM/TO DTS NOT = SERV LN DTS	The statement dates and line item dates must correspond. To avoid this rejection be sure the Statement From Date is equal to the earliest Line Item Date and the Statement To Date is equal to the latest Line Item Date.
83964C: ICD-10-CM Diagnosis Code Invalid	Effective the Date of Service 10/1/2015, claims must be submitted with a valid ICD-10 diagnosis code. This rejection is often paired with 140151: PRIN DIAG MUST BE VALID ICD-10 code. To avoid this rejection, claims for dates of service 10/1/2015 and after must be submitted with the appropriate ICD-10 diagnosis code.

Denial Reason	Additional Information
Explanation Code W22	Facilities offering more than one level of service will likely have more than one provider number. To avoid this denial, claims must be submitted with the appropriate taxonomy code and revenue codes for the service provided.
Explanation Code WK6	All ICF and SNF claims must be submitted with Occurrence Code 54. To avoid this denial, be sure your claim is filed with Occurrence Code 54 and the last date of a physician follow up visit to the patient/member.
Explanation Code TR0 or AUT	This denial is generated when an authorization is not on file for the service billed. To avoid this denial, be sure you have an authorization for the services provided to the member, prior to submitting your claim. You may contact Customer Service via phone or email GM, Provider Authorization Issues for assistance.
Explanation Code WE0	This denial is generated on Nursing Facility claims when the level of care submitted does not match the member's LTC information. A corrected claim may be required. At times, the member's information may change after the claim has been processed. If you feel this denial is received in error, please contact Customer Service for a reconsideration of the claim.

Questions

Please contact the provider network manager in your region if we can help you with any questions about the CHOICES program.

Provider Network Managers			
Manager	**Region**	**Phone**	**Email**
Bianca Merrell	East Tenn.	(423) 535-5900	bianca_merrell@bcbst.com
Jonathan Miller	East Tenn.	(423) 854-6001	jonathan_miller@bcbst.com
Jeff West	Middle Tenn.	(615) 565-1937	jeffrey_west@bcbst.com
Vinny Cardi	Middle Tenn.	(615) 565-1907	vincent_cardi@bcbst.com
Ashley McDonald	West Tenn.	(901) 544-2136	ashley_mcdonald@bcbst.com
Sherry Metts	West Tenn.	(901) 544-2459	sherry_metts@bcbst.com