BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

MARCH 2016

Employment and Community First CHOICES Program to Launch in July

The State of Tennessee is preparing to launch a new program July 1, 2016, that will help provide long-term services and supports (LTSS) to people with intellectual and developmental disabilities (I/DD).

The program, called Employment and Community First (ECF) CHOICES, is different than any existing program in Tennessee. It will be a different way to think, plan and support people with I/DD. With ECF CHOICES, Tennessee will be the first state to develop a program specifically geared to promote and support integrated, competitive employment and independent living as the first and preferred option for people with I/DD.

ECF is for people with intellectual and other developmental disabilities who are not currently receiving services. Those who are in current waivers are not impacted, but can choose to move into the new program in the future.

Tiered Benefit Structure Group Levels

1. **Essential Family Supports**: targeted to people living at home with their families who meet nursing facility or "at risk" levels of care
2. **Essential Supports for Employment and Independent Living:** targeted to people who want to achieve independent living outcomes with priority to people leaving high school who meet "at risk" levels of care
3. **Comprehensive Supports for Employment and Community Living:** targeted to people who need a more comprehensive level of support and meet nursing facility levels of care

The following waiver services will be available based on assessed participant need:

Different Employment and Services Supports:

- Exploration
- Discovery
- Benefits Counseling
- Situational Observation and Assessment
- Job Development or Self-Employment Plan
- Job Development or Self-Employment Start Up
- Job Coaching Competitive, Integrated Employment or for Self-Employment
- Co-worker Supports
- Career Advancement
- Supported Employment – Small Group Supports
- Integrated Employment Path Services (Time Limited Pre-Vocational Training)

Other (non-employment) Services & Supports

- Independent Living Skills
- Community Integrated Support Services

(CONTINUED)

- Personal Assistance
- Community Transportation
- Community Living Supports (CLS)
- Community Living Supports Family Model (CLS-FM)
- Assistive Technology, Adaptive Equipment and Supplies
- Minor Home Modifications
- Individual Education and Training Services
- Peer to Peer Support and Navigation for Person Centered Planning, Self-Direction, Integrated Employment/Self Employment, and Independent Community Living
- Specialized Consultation and Training
- Adult Dental Services
- Respite
- Supportive Home Care (SHC)
- Family Caregiver Stipend in lieu of SHC
- Family-to-Family Support
- Community Support Development, Organization and Navigation
- Family Caregiver Education and Training
- Conservatorship and Alternatives to Conservatorship Counseling and Assistance
- Health Insurance Counseling/Forms Assistance

For additional information, please contact your Provider Relations Representative.

CHOICES Critical Incident Reporting

Your organization is required to have a process in place to provide and document initial and ongoing education to your employees who provide services to CHOICES members, including critical incident reporting.

Your policies and procedures must be adequate and inclusive of all details surrounding this process. During your site visits, the provider network manager will review each policy and procedure to determine if the details documented support the contractual agreement noted in C.R.A 2.15.7.

Critical incident reporting is required by the Bureau of TennCare and must meet certain timeframes. Please see the following ***REQUIRED*** timelines for critical incident reporting:

- 24-hour verbal notification to BlueCare Tennessee by calling 1-888-747-8955
- 24-hour reporting to Adult Protective Service if incident is abuse, neglect or exploitation
- 48-hour written report to BlueCare Tennessee by email to CHOICES_Quality@bcbst.com or by fax to (615) 565-1923 or 1-855-292-3715
- 20-day full follow-up investigation

Some critical incidents can be prevented by your agency through employee and member education. The following are tips to educate your employees, and possibly members, to help prevent critical incidents.

Not all critical incidents can be prevented, and your agency must continue to report any allegations that meet the critical incident guidelines. The following is a list of suggestions, but should not be used as the primary training for your agency's critical incident reporting.

- Ensure employees understand the difference between medication administration and medication assistance
- Remind members to place medications and valuables (including cash, debit cards, etc.) in a secure location and out of plain sight
- Remind employees to stay in sight of members while providing services, when possible
- When members move, educate employees to help prevent falls by assisting the member
- Educate employees to report changes in a member's condition per your agency's policies
- Remind employees to always provide receipts for errands that they complete for members
- Educate employees to report disagreements they have with members per your agency's policies

Any allegations meeting critical incident criteria should be reported to BlueCare Tennessee within the required timeframes. Your agency should use the BlueCare Critical Incident Report form and submit within the required timeframes to CHOICESQuality@bcbst.com or by fax to (615) 565-1923 or 1-855-292-3715. If you have questions or concerns about critical incident reporting, please email us at CHOICESQuality@bcbst.com.

Nursing Facility Billing Guidelines and Benefit Limits

The following items must be submitted on CHOICES Nursing Facility claims:

- Admission/Start-of-Care date (FL12 of the UB) is required. This date must be specific to each episode of care.
- Occurrence Code 54 and the corresponding last date of a physician follow-up visit are required on all Intermediate Care Facility (ICF) and Skilled Nursing Facility (SNF) claims.
- Occurrence Code 55 and the corresponding date of death are required on all claims submitted with Discharge Status 20, 40, 41 or 42. This is in addition to Occurrence Code 54.
- A valid Attending Provider NPI is required on all ICF and SNF claims.

Billing Codes and Benefit Limits

Revenue Code	Procedure Code	Modifier Code	Services and Descriptions	Benefit Limit	Type of Bill
0191			Level 1 (ICF)		066X
0192			Level 2 (SNF)		021X
0192	94004		Level 2 – Enhanced - Chronic Ventilator Care		021X
0192	94004	52	Level 2 – Enhanced - Tracheal Suctioning		021X
0183			Therapeutic Leave - Overnight home visits for ICF only	Total of 10 Days per Fiscal Year	066X
0185			Nursing Home - Hospital bed hold for ICF only		
0189			Non-covered day - ICF, SNF, and ICF-MR		066X or 021X
0224			Date of Discharge if Patient's discharge status is deceased		066X or 021X
0224	94004		Date of Discharge if Patient's discharge status is deceased – Enhanced - Chronic Ventilator Care		021X
0224	94004	52	Date of Discharge if Patient's discharge status is deceased – Enhanced - Tracheal Suctioning		021X

Most Frequently Seen Denial Explanation Codes

Explanation Codes (EX)	Statement on Remittance Advice	Additional explanation about why code was used
W22	This is not a valid revenue code for this provider. The provider should refer to billing guidelines.	This EX Code is generated when the revenue code submitted is not valid for the provider. For example, if a level 2 provider files revenue code 0191 for level 1 services, the claim will deny W22. A corrected claim must be submitted.
XD1	Definite Duplicate Charge Providers Different	This charge is a duplicate of a previously submitted charge for this member.
SHD	Definite Duplicate Charge	This charge is a duplicate of a previously submitted charge for this member.

Members' Plans of Care to Arrive by Secure Email

BlueCare CHOICES will begin forwarding the member's Plan of Care (POC) via secure email. 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.

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.

Plan of Care Attestation Reports Available to Providers in EVV Database

BlueCare CHOICES providers are now able to access the Plan of Care Attestation Report within their EVV Database. Providers should use the Plan of Care Attestation Report to verify that Plans of Care are received for each member receiving service.

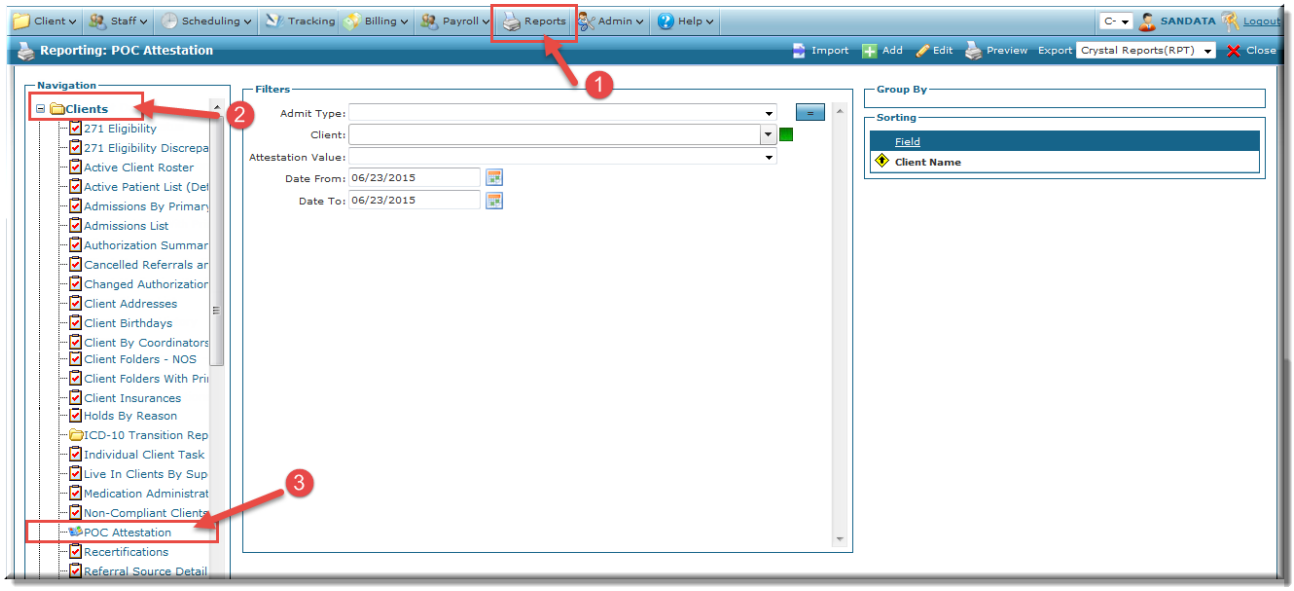
By clicking the **Reports Tab**, a Navigation pane will open, which guides you to the folder "Clients." The Clients folder, will display a series of check boxes. Click on the check box titled, "POC Attestation." The available filters on the POC Attestation Report are: admit type, client (member) and attestation value.

Once you select your appropriate filters, the authorization data will show the date the authorization was received in the EVV System, authorization number, authorization start date, and service(s) for each member.

The report also captures client data which includes member name and member ID.

The provider data includes the date attestation was completed, the login ID of the user who marked the attestation complete, the provider name and provider number. The Report can be saved as a PDF document or exported in various formats such as Word, Excel and Excel data only.

Providers are required to review and approve all plans and certify receipt through attestation. Your organization should ensure that each employee serving a CHOICES member receives a copy of the Plan of Care and follows through on directives included in the plan.



Electronic Visit Verification Maintenance

As a BlueCare CHOICES provider, you should be aware of the appropriate processes relative to the EVV system. It is a requirement set forth and verified in your policy that you have one full-time person monitoring your EVV (you should also have a minimum of one back up, however two are recommended).

- The provider-dedicated EVV representative will work to minimize late/missed visits through proactive phone calls to the EVV Support Department, immediately when and if changes occur. If you will not be able to provide services as authorized or when deviations occur from the approved plan of care, please contact our EVV Support Department at 1-800-468-9736, to ensure the member's back up plan is initiated and to prevent the member from going without their approved services. It is the provider's responsibility to contact the EVV Support Team when there are deviations from the members' schedules.

- The EVV Support Department can be reached during regular business hours at 1-800-468-9736 or via email for ***non-urgent*** matters at Providerauthissues_GM@bcbst.com.

- If the occurrence is after business hours, during the weekend or on a holiday, please call the 24/7 Nurse Line at 1-800-262-2873. Schedule deviations are handled accordingly to ensure members have continuity of services. Be sure to document the time you call and with whom you spoke.

- The provider-dedicated EVV person should inputreason and resolution codes into the EVV Database for all late/missed visits in a timely manner. Once this process is completed, a request must be submitted to have the units released for the applicable late/missed visits. If no calls or check-in/check-out are visible in the EVV Database, timesheets that show time/date/services provided to the member must be signed by the member and the caregiver on the date the services were rendered. This documentation will need to be submitted as proof the services were rendered at the time of the unit release requests.

- Please remember that keeping your EVV Support Team engaged minimizes any additional steps and workload in managing the EVV billing requirements.

Important to remember:

- **Sandata GPS Device**: All workers should be utilizing Bureau-mandated GPS Devices/Tablets to check in/out. If the member does not have a tablet in the home, please contact the EVV Support Team at 1-800-468-9736 to initiate the deployment of a device to the member. If there are technical issues please sign in/sign out utilizing the telephony method provided by Sandata. ***When the caregiver experiences GPS Device/Tablet technical issues, please call the Sandata Customer Support at 1-855-389-4843 and be sure to obtain an inquiry tracking number. The inquiry tracking number must be reported to the EVV Support Team to initiate timely resolution.***

- **One-Time Schedule Changes** should be requested by the member. Provider-initiated schedule changes will be verified with the member to obtain approvals for schedule deviations. Approvals are not guaranteed.

- **Timely Filing Limits** are 120 days from the date of service or within 60 days from the date of the original rejection notice, whichever is later.

CRA Amendment Changes

New CRA amendments went into effect Jan. 1, 2016. A synopsis of the changes is below. If you were not able attend the webinars where we introduced the changes and you have questions about the new amendments, please contact your Provider Network Manager.

A synopsis of the changes:

- **Billing and Reimbursement for current Adult Day Care providers -** EVV no longer is the route to submit a claim for a BlueCare CHOICES member. BlueCare will utilize our web portal, so please make sure you have registered.
- **Employee Educational Requirements -** There are new requirements for employees working with CHOICES members. Topics include: Orientation to populations the staff will support; Disability awareness/caring for the elderly, adults and members with physical disabilities; Cultural competency, including person-first language and etiquette when meeting and supporting persons with a disability; working with individuals who use alternative forms of communication; ethics and confidentiality including HIPPA and HITECH; delivering person-centered services and supports to include facilitating individual choice and control; an introduction to behavioral health; promoting health lifestyle choices and supporting self-management of chronic health conditions; GPS workers survey completion requirements-workers must complete at every end of shift; Federal HCBS setting requirements and the importance of the member's experience; supporting community integration and participation in the delivery of HCBS; and working with family members and/or conservators while respecting individual choice.

BlueCare will create a useful resource tool/links to assist providers in gaining compliance with training materials and policies, as well as employee training records. As a reminder, this resource tool/link will be created to assist your agency in becoming compliant. It is quite possible your agency is already completing the above educational requirements. Ask your assigned Provider Network manager for assistance.

CHOICES Provider Agreements will have some changes. In particular, when a member initiates a provider change, the provider is expected to continue to provide services until the member is transitioned, unless the member is in immediate jeopardy or the member's health and welfare would otherwise be at risk remaining with the current provider. Also, providers are required to report deviations from a member's service schedule, as these changes will affect service authorizations.

Community Living Support Providers and Community Living Support – Family Model Providers

There are additional CRA Amendments that reference safety requirements, person-centered practice requirements, staff qualification requirements, community representation requirements, residential provider requirements, liability and insurance requirements and blended facilities requirements. These will apply to CHOICES providers, as well as ECF CHOICES providers.

The safety requirements for the provider center around developing and maintaining policies concerning:

- Fire evacuations and natural disasters, identifying and reporting any problems relating to sanitary and comfortable living environment and routinely inspecting provider-owned vehicles, including employee-owned vehicles used to transport members.
- Crisis intervention includes instructions forn the use of psychotropic medications and behavioral safety interventions, if applicable
- Member complaint resolution process
- Administration of medications according to physician orders by trained and qualified staff.
- Medication administration records are properly maintained and that all medications are properly stored and accessible when needed

- Tracking and trending medication variance and omission incidents

Managed Care Organizations are responsible for developing the member's person-centered plan, and the CRA now includes the person centered practice requirements for providers that focus on developing and maintaining policies to ensure providers treat members with dignity and respect, as evidenced by:

- Ensuring members/representatives and family members are given the opportunity to participate in the selection and evaluation of direct support staff
- Soliciting member/representative and family feedback on provider services
- Ensuring members/representatives have information to make informed choices about available services
- Ensuring members are allowed to exercise personal control and choice related to their possessions
- Supporting members in exercising their rights
- Periodically reviewing members' day services and promoting meaningful day activities
- Supporting members in pursuit of employment goals
- Only restricting members' rights as provided in their person-centered support plans
- Staff training on person-centered practices

The new qualified staffing requirements include ensuring all staff has appropriate, job-specific qualifications; verifying prior to employment, and routinely after, that all staff have all required licensure and certification; and ensuring all staff receive ongoing supervision consistent with their job functions.

All CLS providers must also ensure that the composition of the provider board of directors, or community advisor group, reflects the diversity of the community they serve and is representative of the people served.

Residential providers must meet some additional requirements. Residential providers must develop and maintain policies to ensure that members' dietary and nutritional needs are met, while being able to exercise personal choice. Residential providers also must have policies and procedures to manage and protect members' personal funds.

All providers are required to carry adequate liability and insurance at or above limits established by TennCare. Worker's Compensation must include all States' coverage and have a limit not less than $750,000 per occurrence. Comprehensive Commercial General Liability must include coverage for personal injury and property damage, premises/operations, independent providers, contractual liability and completed operations/products coverage.

This comprehensive commercial general liability coverage must include bodily injury/property damage with a combined single limit not less than $750,000 per occurrence and $1,500,000 aggregate. All CLS providers must maintain automobile coverage for owned, leased, hired and non-owned vehicles that are covered for bodily injury/property damage at a combined single limit not less than $1,500,000.

For blended facilities, providers must allow DIDD staff access to pertinent CHOICES member information during critical incident investigations in blended facilities. Providers with blended CLS homes must comply with DIDD investigations.

Minor Home Modification Program

Warranty Service, Quality and Callbacks

As contractors/providers often have to assume the cost of callbacks, even when they come from damage inflicted by others when the work is done, it is obviously worthwhile to find ways of reducing these callbacks and their associated costs.

Making Quality #1

The way a provider can improve quality is by being on site more and consistently managing/overseeing the employees completing the work. It's the day we don't go out on the jobsite and something slides by that allows for callbacks to begin.

One frequent response is "I didn't have time" or we don't have time to do it that way." These responses lead to additional concerns. If you don't have time to do the job right, where will you find time to do it over?

Other callbacks include members changing their minds or damage after job completion. This is where vital and timely documentation is crucial. Contractors with a good Quality Control Program will always perform a Pre-Construction Meeting with Owner/Member and a final walkthrough with the Owner/Member upon completion and have them sign off on the job. If you don't have a Quality Assurance Program, BlueCare CHOICES encourages you to create one today.

We all strive to keep call backs to a minimum and provide the best service possible to our members.

It is BlueCare CHOICES policy to complete and close callback reviews in 14 working days. If the callback concerns a safety item, it must be completed in 72 hours when possible. We will also need notification of completion of these repairs with pictures for documentation as soon after the repair as possible.

As much as we prefer to not receive callbacks, they are not terminal and they are certainly not a dirty word when Contractors/Providers take measures to reduce them.

For more information on these policies, contact your Regional Home Modification Specialist.

Home Modification Specialists		
Manager	**Region**	**Email**
John B White	West	John_White@bcbst.com
Steven Hargis	East	Steven_Hargis@bcbst.com

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. – South Region	(423) 535-5900	bianca_merrell@bcbst.com
Jonathan Miller	East Tenn. – North Region	(423) 854-6001	jonathan_miller@bcbst.com
Jeff West	Middle Tenn. – South Region	(615) 565-1937	jeffrey_west@bcbst.com
Vinny Cardi	Middle Tenn. – North Region	(615) 565-1907	vincent_cardi@bcbst.com
Ashley McDonald	West Tenn. – East Half/Shelby County M-Z	(901) 544-2136	ashley_mcdonald@bcbst.com
Sherry Metts	West Tenn. – West Half/Shelby County A-L	(901) 544-2459	sherry_metts@bcbst.com