BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

October 2014

Welcome to Middle Grand Region Providers; BE IN THE KNOW

We invite you to attend one of our FREE statewide Town Hall Meetings to learn more about the TennCare CHOICES Long-Term Services and Supports Program hosted by BlueCare Tennessee. All newly - enrolling Grand Middle Region providers, along with currently contracted CHOICES providers, are encouraged to attend one of these informative sessions in November 2014.

Topics of Interest

- CHOICES 101
- Submitting clean claims
- Critical incident reporting
- Credentialing and contracting process
- Care coordination, and much more!

Locations:

- Nashville – Nov. 5, 2014
- Jackson – Nov. 6, 2014
- Memphis – Nov. 7, 2014
- Johnson City – Nov. 10, 2014
- Knoxville- Nov. 11, 2014
- Cookeville – Nov. 12, 2014
- Chattanooga – Nov. 13, 2014

Pre-registration is requested. Location and times will be sent via e-mail and fax. If you need additional information, or need to submit an updated e-mail address or fax number, please contact BlueCare CHOICES Customer Service at 1-800-468-9736 or 1-800-278-1978. Details will be published on the BlueCare Website soon.

BlueCare CHOICES Hospitalization Reporting

Hospitalizations increase our BlueCare CHOICES members' risks for functional ability loss, and health related complications.

It is our obligation to promptly evaluate CHOICES members' for significant changes after hospitalization so that needed adjustments to the members' Home and Community-Based Services (HCBS) Plans of Care, level of care transitions and/or transition between CHOICES Groups can be completed.

Anytime you, the HCBS Provider, become aware of a CHOICES member's hospitalization, you are requested to report this to BlueCare CHOICES in the same day you obtain this information. Reports can be submitted during normal business hours by phone to BlueCare CHOICES, and to the Nurse Line for after-hours reporting (nights, weekends and holidays).

Contact Information

BlueCare CHOICES:	1-800-468-9698
NurseLine:	1-800-262-2873

HCBS Workers and Medication Assistance

TennCare rules state that "medication assistance" means providing medication reminders and opening medication packaging, but does not mean giving the service recipient injections or any form of medication administration that would be only appropriate and acceptable for persons who are authorized to do so by Title 63, Chapter 7.

Medication assistance is allowed, and is defined as:

1. Loosening the cap on a pill bottle for oral medication
2. Opening a pill reminder box if the box is filled by the member, authorized representative or licensed medical personnel practicing within the scope of their license
3. Placing medication within reach of the member
4. Holding a member's hand steady to help them with drinking liquid medication
5. Guiding the member's hand when the individual is applying eye/ear/nose drops and wiping the excess liquid
6. Helping with a nasal cannula or mask for oxygen, plugging the machine in and turning it on
7. Applying non-prescription creams and lotions purchased over-the-counter to external parts of the body
8. Providing medication reminders and medication handling reminders.[i]

Anything beyond the duties of medication assistance as defined by the state guidelines could result in legal action, fines or possible contract termination.

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[i] TennCare Rules and Regulations, Definitions, 63 sec. 0940-05-38.10, Chapter 7. https://www.tn.gov/sos/rules/0940/0940-05/0940-05-38.20100218.pdf

Credentialing and Re-credentialing Readiness for CHOICES Provider Site Visits

BlueCare appreciates the participation of the Home and-Community Based Services (HCBS) contracted providers. In an effort to provide helpful information to assist with retaining a preferred network status, please read this important information regarding the required Standards and Documentation Review. For newly enrolling providers, BlueCare will conduct a site visit at the provider's practice or business location in order to complete the credentialing process. If you are currently enrolled as an established CHOICES provider, you will be required to complete the re-credentialing process. In accordance with the TennCare Contractor Risk Agreement, and in conjunction with the NCQA Standards and Guidelines for Accreditation, BlueCare facilitates annual (or as required), provider credentialing reviews.

As a newly enrolling provider, credentialing for the BlueCare Tennessee CHOICES program will include collecting several business documents, disclosure forms, and the completion of the Provider Application. During the site visit, employee records will be reviewed along with validating appropriate policies and procedures are in place.

At a minimum, re-credentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV, or use of the web portal. BlueCare verifies on a monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

What You Need to Know for Site Visit Preparation

1.) Review all documentation provided to your office prior to the visit, including the pre-defined checklist
2.) Have in place written policies and procedures to support hiring practices, including background checks from all applicable registries, and proof of monthly monitoring
3.) Provide proof and documentation of initial and ongoing education for employees and be able to supply employee records during site visit
4.) Present copies of all current and required licensure
5.) Policies and procedures must be available for the auditor to validate compliance with critical incident reporting

If during the site visit any deficiencies are identified, the auditor will communicate any corrective actions required to become compliant. Complete details regarding the Provider credentialing and site visit

process can be found on the BlueCare Tennessee website in the Provider Administration Manual located in the CHOICES section under Provider Contracting/Credentialing.
BlueCare Tennessee Provider Administration Manual

Electronic Visit Verification (EVV) Training

BlueCare Tennessee is enhancing our Electronic Visit Verification (EVV) authorization process. We are also implementing changes to the EVV system that will improve the scheduling process for providers.

EVV Providers that were unable to attend the Webinars conducted in September can review the materials covered by accessing the following link;
Sandata Library-
http://webtraining.sandata.com/tenncare/
User Name: nhtraintn
Password: 3stars
BlueCare Specific Documentation: Design

Please contact your CHOICES Provider Relation Consultants with any questions you may have.

East Region Bianca Merrell
(423)-535-5900 bianca_merrell@bcbst.com

Middle Region Jeff West
(615)-565-1937 jeffrey_west@bcbst.com

Middle Region Vincent Cardi
(615)-565-1907 vincent_cardi@bcbst.com

West Region Ebony Williams
(901)-544-2459 ebony_williams@bcbst.com

BlueCare Tennessee CHOICES EVV Providers

Providers **cannot** make requests for in-home respite. The **Member** must be the one who makes a request for in-home respite.

What is In-Home Respite?

- In-Home Respite is available for both Group 2 and Group 3 members and must be included on an approved Plan of Care.
- It is provided on a short term basis ***in the member's home.***
- It is offered in the absence of the natural caregiver who normally provides care for the member.
- It is offered for the relief of the natural caregiver who normally provides care for the member.

What cannot be covered under In-Home Respite?

- In-Home Respite **cannot** be used to take the member out of their home, i.e. for a doctor's appointment or dialysis visit.
- It cannot be used to add more Personal Care or Attendant Care services.

How should In-Home Respite be requested?

- The Member may send requests for In-Home Respite to the Support Center at 1-888-747-8955, option 1.
- In-Home Respite must be approved prior to providing the service to the ember. Approval is not guaranteed.
- The Support Center will verify with the member that In-Home Respite has been requested and that it is needed for a covered reason.

Things to keep in mind:

- Do not encourage members to use their In-Home Respite as quickly as possible.
- If a member has In-Home Respite available, they only have 216 hours for the entire calendar year. This benefit should be used on an as-needed basis only.
- The member isn't penalized for not using in-Home Respite. It isn't a "use it or lose it" benefit.

Authorization Questions:

Call the Support Center at 1-800-782-2433, option 1 if you experience the following issues:

- The information provided during the phone call with the Support Center staff is not the same as what is listed on the form;
- The form is not legible and needs to be resent
- Questions about the tasks that need to be provided;
- If the authorization for a service is about to expire.

Schedule Changes:

How are one-time schedule changes requested?

- Providers **cannot** make requests for one-time schedule changes due to staffing issues
- The **Member** must be the one who makes a request for a one-time schedule change
- Providers can provide the Member with the information to make such request. The Member can make the request by calling 1-888-747-8955, option 1.
- BlueCare Support Center Management either approves or denies one-time schedule change.
- Support Center staff member revises authorizations, as needed.
- Support Center staff notifies all parties (CC, Member, Provider) via email and/or phone, as applicable, that one-time schedule change request is either approved or denied

Missed/Late Visit Process:

Per your contract, you are required to immediately contact BlueCare via e-mail at providerauthissues_gm@bcbst.com or via the BlueCare provider line at 1-800-468-9736 if there is any deviation from authorized services. If you need to report a missed/late visit after normal business hours, call 1-800-262-2873.

- All visits/services must be scheduled in EVV
  - Prior to the staff worker providing services
- Visits should never be cancelled
  - Any time scheduled services are not going to be provided to a CHOICES member, BlueCare must be notified immediately
- The provider shall provide backup
  - The Provider shall ensure the backup staff meets the qualifications for the Covered Service
  - The Provider must ensure that it has sufficient staff to provide services in accordance with the PPOC
  - The Provider is responsible for having adequate backup staff in the event that the originally scheduled worker cannot provide services in accordance with the PPOC
- Missed visits increase Provider liability
  - An explanation must be provided in EVV if a visit does not occur
- Provide an accurate reason & resolution status:
  - If services were provided however the visit went missed, the provider must send in a signed time sheet with the date of services, task provided, and the member or member representative's signature attesting to services being provided. This information is reviewed and stored in the member's record for auditing purposed. Without this signed document, units will not be released in the EVV system which will not allow the provider to bill for services.

****** All providers have 120 days from the date of service provided to submit claims. If claims are not submitted timely, there is not an option for overriding timely filing. It is the provider's responsibility to promptly notify BlueCare Tennessee (BCT) of any claims submission issues to ensure they do not incur timely filing denials.***

Sandata Claims and Corrected Bills

After the initial submission of a claim via Sandata, any additional submission must be identified as a corrected claim. This is regardless of the reason for the resubmission.

Examples:

- After a claim is submitted for 16 units of attendant care, it is discovered that 18 units of service were provided. The resubmission should have 18 units and should be identified as a corrected claim
- After submission, it is discovered that a claim was attributed to the incorrect worker. Upon correcting the worker's name, the claim must be identified as corrected claim and resubmitted

Appropriately identifying these claims as corrected bills will further ensure appropriate processing and payment of your claims.

BlueCare Tennessee CHOICES HCBS Critical Incident Reporting

Our CHOICES members depend on BlueCare and our Home and Community-Based Services (HCBS) providers for their safety. It is our obligation to ensure precautions are taken to protect our members during the provision of covered HCBS. Any time you become aware of an incident that may involve the provision of HCBS, you are obligated to report it to BlueCare timely. If the incident involves the HCBS worker or workers, he or she must be immediately removed from serving all TennCare members for the duration of the investigation.

The maximum timeframe for reporting a HCBS Critical Incident to BlueCare CHOICES is twenty-four (24) hours.

If the initial report is submitted verbally, a follow-up written report is due within forty-eight (48) hours.

Verbal reports may be submitted by phone: BlueCare Tennessee 1-888-747-8955; 24-hours-a-day, 7-days-a-week.

- The phone line is monitored nights, weekends, and holidays by the Nurse Line and calls are routed to the on-call CHOICES Supervisor

Written reports may be submitted by fax or secure e-mail:

- Fax: (615)-565-1923
- SECURE e-mail: CHOICESQuality@bcbst.com
- Any written reports of physical or sexual abuse or unexpected death must also be phoned to the BlueCare Tennessee number listed above

If abuse, neglect, or financial exploitation* is suspected or alleged, you must also notify Adult Protective Services (APS) immediately and within 24 hours at 1-888-277-8366, or by fax at 1-866-294-3961.

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

Transition Plan & Documents for New Federal HCBS Rules

Providers can view the finalized transition plan and documents on the Tenn. Care website located @ http://www.tn.gov/tenncare/long_hcbstransition.shtml. Statewide training for providers and coordinators on the assessment tools will be conducted Oct. 15 – Nov. 15, 2014. Additional details regarding these training sessions will be provided in the coming weeks.

Three (3) areas of focus to ensure individual needs are integrated in and supports access to the greater community are; 1). Provides opportunities to seek employment and work in competitive integrated settings, 2). Supports engagement in community life and assists control of personal resources; 3). Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services.

All providers that own and provide residential service and non-residential providers such as Adult Day Care will be required to complete a Provider Self-Assessment for these settings. The Provider Self-Assessment tool will be provided by TennCare and will be reflective of questions recommended by the Center for Medicare and Medicaid Services (CMS) as part of the assessment process. The assessment will encompass results of the nature and quality of experience of individuals supported by the provider or agency. The assessment should include all levels of management, direct support staff, and individuals and families served in their programs. The self-assessments are due October 15, 2014 - March 31, 2015. The State will conduct statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool Oct. 15, 2004 – Nov. 15, 2014. Please contact your Provider Network Manager if you have additional questions and see details of the plan **Tennessee Home and Community Based Services Transition Plan**.

October 2014

Implementing the HCBS Final Rule: *HCBS Provider Self-Assessment*

- HCBS providers will be required to complete a self-assessment to help determine compliance with HCBS setting rules.
- Self-assessment tool provided by TennCare.

The tool is qualitative in nature—See "Exploratory Questions" at: **Exploratory Questions to Assist States in Assessment of Residential Settings**

- DIDD and MCOs will distribute tool and oversee self-assessment process.
- If contracted with > 1 MCO and/or enrolled as an ID waiver provider, only **one** self-assessment per site/program is required.
- One self-assessment **per** facility owned/operated.

Transition Plan/Time Line Activity	**Time Line**
Finalize proposed transition plan and submit to CMS	Oct. 1, 2014
State self-assessment	Ongoing – Feb. 28, 2015
Contracted entity (MCO) Self-Assessment	Oct. 1, 2014- March 31, 2015
Provider self-assessment	Oct. 15, 2014- March 31, 2015
Individual experience assessment	Nov. 1, 2014 – Oct. 31, 2015
Validate provider self-assessments and approve corrective action plans	June 30, 2015
Track corrective action activities	To be determined

Please contact your Provider Relation Consultant if you have additional questions.

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