BlueCare Tennessee

CHOICES NEWSLETTER

BlueCare Tennessee CHOICES Program

April 2015

Billing Guidelines

Nursing Facility

- Admission / Start-of-Care date (FL12 of the UB) is required. This date must be specific to the 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 National Provider Indicator (NPI) is required on all ICF and SNF claims.

Home and Community Based Services (HCBS)

- Type of Bill is 089X.
- Admission / Start-of-Care date (FL12) is required. This date must be specific to the episode of care.
- Type of Admission (FL14) is required. This code indicates the priority of this admission.
- Point of Origin for Admission or Visit (FL15) is required.
- Occurrence Code 55 and the corresponding Date of Death are required on all claims submitted with Discharge Status 20, 40, 41 or 42.
- Attending Physician (FL76, 1 & 2) is required on all HCBS claims as follows:
    - Consumer Direction (CD): The worker's assigned CD number will be submitted as the Attending Provider. The ID must be within the range of CD00001 – CD99999.
    - Attending Providers with an NPI: The provider's NPI will be submitted as the Attending Provider. The NPI must be valid and recognized by BlueCross BlueShield of Tennessee.
    - Atypical Attending Providers without an NPI: The provider's 7-digit Medicaid ID number will be submitted as the Attending Provider. The Medicaid ID number must be valid and recognized by BlueCross.

Claims Explanation Codes

Please refer to the following information in the event you see these denials on your Remittance Advice. Please contact Customer Service should you have any questions about claims processed with these, or any other Explanation Codes.

W22: This denial 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.

SHD/DUP: These denial EX codes are generated when a duplicate claim is submitted. Please refer to your remittance advices to avoid duplicate claim submission. If a claim has been denied and you have questions regarding the denial, please contact Customer Service for assistance prior to resubmitting the charges.

April 2015

Timely Filing- Rejected Claims and Corrected Claims

Rejected Claim Timely Filing

If you have filed a claim that BlueCare Tennessee (BCT) rejects, you may wish to make corrections and resubmit. Rejected claims must be resubmitted within 120 days of the date of service or within 60 days from the date of the original BCT rejection notice, whichever is later.

Corrected Claim Timely Filing

Timely filing for corrected bills is 120 days from the remittance date of a claim. If there are multiple submissions of a corrected bill, the first submission of the corrected bill will be used for adjustment.

CHOICES Customer Service Menus

Our CHOICES customer service menus are changing in an effort to streamline the process for our Providers needing assistance with CHOICES Members.

After selecting Option 6 from the Main Menu, the following options will be offered:

- Press 1 for assistance with an authorization related to the member's Plan of Care
- Press 2 for assistance with a late or missed visit
- Press 3 to refer a member for the CHOICES Program
- Press 4 for assistance with a claim or payment question

Deficit Reduction Act-Fraud and Abuse

Overview

The Deficit Reduction Act (DRA) was passed by Congress in 2005 and went into effect on Jan. 1, 2007. The DRA impacted all federally funded healthcare programs, including State health care programs such as TennCare. As a result, the MCOs that manage TennCare benefits made some changes to comply with the new legislation.

One provision of the DRA was that it allowed the State to rebalance long-term care support systems. As a result, TennCare launched the CHOICES program in 2010.

BCT CHOICES providers play an important role to the success of this program through servicing members, but just as important filing accurate claims. This is requirement from BCT CHOICES, and, also the federal government.

A vital part of the DRA, is the False Claims Act. BCT CHOICES providers are responsible for submitting claims accurately, which includes every component of the submission. The liability of submitting false claims is a global responsibility of providers and their entire organization. The following examples provide critical examples of your responsibility to this law:

- Anyone who knowingly submits a false claim for payment:
- Anyone who conspires to get a false claim paid;
- Anyone who documents that a product/service is delivered/rendered without knowing for sure;
- Anyone who produces, uses, or causes use of false documentation that leads to avoiding, concealing, or reducing an obligation to pay or transmit money/property to the Government;
- Anyone who produces, uses, or causes use of false documentation that leads to a false/fraudulent claim being paid or approved;
- Anyone who has possession of property/money used or to be used by the Government that has been concealed or reduced from the amount that was to be delivered;
- Anyone who buys or receives pledge of an obligation or debt/property from a government officer/employee or member of the Armed Forces who cannot sell or pledge the property for themselves because of their position.

Whistle Blowers are Protected

Any employee who has knowledge of false claim submission should report it. The law protects employees from employer retaliation following a report as long as the employee reasonably believes he/she is reporting a violation of the law. As a result, the employer cannot discharge, demote, suspend,

harass or in any manner discriminate against the employee for making a good-faith report. If the report meets the specific legal requirements, the reporter could possibly be awarded 15-30% of the total recovery.

If you suspect fraud, there are several options for filing a report:

- Call BlueCross BlueShield of Tennessee's Fraud and Abuse Hotline at 1-888-343-4221
- Online with BlueCross BlueShield of Tennessee at http://www.bcbst.com/fraud/index.page;
- Call the Bureau of TennCare from anywhere in Tennessee at 1-800-433-3982; or
- Log onto http://www.tn.gov/tnoig/ReportTennCareFraud.shtml

BCT CHOICES is committed to empowering our providers, providing you with the mandatory required training for the DRA is our responsibility. The Provider Network Managers will ensure that all of the training material, including the required Attestation Form, is reviewed during the site visit.

Here are some important reminders:

- Training is required for all employees. It is recommended that the training be incorporated into new hire training to ensure that all new employees are trained.
- Once all employees complete the DRA training, the training sign-in sheet and the Attestation Form (signed and dated) should be faxed to (615) 386-8589 to the attention of your assigned CHOICES Provider Network Manager.
    - West Grand Region
        - Sherry Metts (sherry_metts@bcbst.com)
        - Ashley McDonald (Ashley_McDonald@bcbst.com)
    - Middle Grand Region
        - Vincent Cardi (Vincent_Cardi@bcbst.com)
        - Jeffrey West (Jeffrey_West@bcbst.com)
    - East Grand Region
        - Bianca Merrell (Bianca_Merrell@bcbst.com)
        - Jonathan Miller (Jonathan_Miller@bcbst.com)
- Training must be conducted every three years for all employees. A new Attestation Form and current training sign-in sheet is required.
- For additional training materials or assistance with employee training, please contact your assigned CHOICES Provider Network Manager.

Community Living Services

Community Living Supports (CLS) is a community-based residential alternative service for seniors and adults with disabilities that encompasses several options for community residential independence through community integration. The CLS service ensures resident's choice and rights and must adhere to the new HCBS setting rule. Please review the following description and FAQ's that provide further details for provider requirements. If you are a qualified provider, and interested in contracting with BCT, please email your organization's information to CHOICESProviderRelations@bcbst.com

CLS services are individualized based on the needs of each resident and person-centered plan of care. The services and support for each individual may include:

- Selecting and moving into a home;
- Locating a suitable house mate;
- Acquiring and maintaining household furnishings;
- Acquiring, and retaining improved skills for daily living activities or assistance with daily needs such as bathing, dressing, personal hygiene, grooming, transferring and mobility;
- Building and maintaining personal relationships with family and friends;
- Gaining employment opportunities or pursuing educational options;
- Scheduling appropriate medical services;

- Participating in the community to include faith based and social events that are selected by the member;
- Becoming aware of and effectively using transportation, the police, fire and emergency services for help, and general community and general public help assistance;
- Meal planning;
- Self- administering of medication, including assistance with administering of medications as permitted pursuant to TCA 68-1-904 and TCA 71-5-1414;

These are just a few of the services that a qualified CLS provider can effectively support the CHOICES member transitioning to the community. Below are some frequently asked questions that will also assist you.

Does the Personal Support Services Agency license cover CLS services?
No, you will need to be licensed as one of the following:

- Mental Retardation Semi-Independent Living Services licensed provider by DIDDS for:
  - CLS1
  - CLS2
  - CLS-FM1
  - CLS-FM2
- Mental Retardation Supported Living and/or residential habilitation facility provider by DIDDS for :
  - CLS3
  - CLS-FM3

Who develops the plan of care?
The CHOICES care coordinators will be responsible for developing the plan of care. The plan of care will include relevant information of the members' services, natural supports, back-up plans, disaster planning, summary of member needs, and member qualification. Each MCO may have different formats but the plans of care will contain the same information.

How will medications be administered?
CHOICES members will be allowed to use self-direction for medication administration if determined appropriate. A verbal order will be obtained from the member's Primary Care Provider (PCP) and included on the plan of care, allowing a paid worker to assist in this health care task. This is limited to the administration of oral, topical and inhaled medications.

When will CLS services become a contracted event?
Currently, BCT CHOICES will enter into single case agreements for qualified providers that meet the CLS standard requirements. For reimbursement and details regarding the process to secure a single case agreement, please contact BCT CHOICES at CHOICESProviderRelations@bcbst.com.

CHOICES Nursing Facility Provider Update

A rather large component of having nursing facility claims paid correctly and on time encompasses a Nursing Facility (NF) to utilize the accurate provider ID numbers. For nursing facilities, please remember that as a CHOICES provider you are given a two different provider ID numbers for Skilled Nursing (SN) and Long Term Care (LTC). To assist with the different provider numbers assigned for BCT CHOICES, we have given your facility one provider number that is for LTC (Level 1) and a separate provider ID number that is given for the SN (Level 2). If questions arise about your provider ID numbers, please contact the assigned Provider Network Manager to your facility to retrieve your two different provider ID numbers.

Please review the updates again for requesting and approving Enhanced Respiratory Care Services for all CHOICES members to meet our contractual agreement with the Bureau of TennCare. The 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:

April 2015

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 BCT 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
6. BCT will provide letters for approval or denial of requests.
7. Required forms to be utilized beginning April 1, 2015.

Critical Incident Reporting Mandatory Timeframes

The following are critical incident mandatory reporting timeframes for BCT CHOICES HCBS services:

- A 24-hour verbal report is required to BCT 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 exploitation* at 1-888-277-8366, or by fax to 1-866-294-3961.
- Immediate reporting to BCT 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 (855) 292-3715.

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

Note: It is a requirement that your organization has a process in place to provide and document initial and ongoing education to your employees who will provide services to CHOICES members. This includes critical incident reporting. Your policies and procedures must be adequate and inclusive 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 2.11.3

Implementation Phase II

As a BCT Provider you are probably aware of the changes that have been going on since Jan. 1, 2015. BCT started receiving transferred members in the Middle Grand Region from the other two participating MCO's while at the same time having some of our members transfer to a different

MCO in the East Grand and West Grand Regions. This was Phase I and the members have already been transferred or opted back to their previous MCO. Phase II is already in motion behind the scenes and the member reassignment date will be April 1, 2015. The member will have the option to opt out of their new provider up to May 15, 2015.

If you have a member who has been notified they will be reassigned there are things you should look for. First, please keep an eye out for an authorization from BCT CHOICES. The authorizations should be the same services you are providing pre-transfer, but if there are any discrepancies please call 1-800-468-9736 or email the specific information to CHOICES_GM@bcbst.com..

Second, if you receive a faxed authorization, but the services are either not showing in the Electronic Visit Verification (EVV)/Sandata system please call the support center at 1-800-782-2433 or email the specific issue to ProviderAuthIssues@bcbst.com.. It is highly recommended to copy your Provider Network Manager on all correspondence so that they are aware of any issues and can assist you in the resolution.

Last but not least, please insure that you have all of the following that apply:

- BCT CHOICES Database in EVV/Sandata (*Attendant Care, Personal Care, In Home Respite, Home Delivered Meals, and Adult Day Care Providers*). If you require further training or do not have this access, please contact your BCT CHOICES Provider Network Manager for the next steps.
- BlueAccess Log In and "Shared Secret" (*ALL PROVIDER TYPES*). Assisted Care Living Facilities, Assistive Technology, Critical Adult Care Homes, Minor Home Modifications, Nursing Facilities, Personal Emergency Response Systems, and Pest Control providers have the option to submit claims via this web portal as well if they choose to not use a third party vendor. If you have more than one provider ID (such as a Nursing Facility that offers Skilled Nursing and Long Term Care) please insure your numbers are linked. If you have any questions regarding BlueAccess, please call (423) 535-5717 option 2.

Thank you again for being a valued provider for BCT CHOICES and if you have any questions, please call provider services or your Provider Network Manager.

HCBS Settings Final Rule

Intent

For the first time, HCBS Settings Final Rule sets federal standards to ensure that Medicaid-funded HCBS are provided in settings that are not institutional in nature. These standards apply to residential and non-residential (for example, day program) services and settings. The rules focus on the ***experience*** of each person receiving services and supports—Are they living the life they want?

Standards that Apply to ALL HCBS Settings

- Integration with community
  - Is the setting a part of the community so that people can access and use their community?
  - CMS expects to see that people in Medicaid HCBS programs have the same chances as everyone else does to be in and use their communities – to find jobs, go to activities in their community, use the library, get a haircut when and where they want, etc.
    - Do people in the setting have access to public transportation?
    - Can people work if they want to?
- Choice
  - Is the setting selected by the individual from among setting options, including non-disability

specific settings and an option for a private unit in a residential setting?
  - This means that the person must be able to choose where they live, not just be 'assigned' to live in a home or setting meant only for people with disabilities.
  - Also, this does not mean everyone gets a private unit. This means that if someone wants AND can afford to live alone, they must be given options of settings that include a private unit.
- Rights
  - The setting must ensure the person has rights of privacy and dignity, and is treated with respect.
  - Are schedules for therapy or medical appointments posted in public areas where everyone can see them?
  - Are people called by their preferred name or are they called "hon" or "sweetie"?
  - The setting must ensure the person will have freedom from coercion and restraint (will not be forced to do things they do not want to do).

- Independence
  - The setting must support the person to maximum their ability to be independent in making life choices, this includes things like:
    - What I do each day
    - Where I live and how it is decorated
    - Who I hang out with
  - The person must be supported to choose the services they need and who provides them

HCBS Provider Self-Assessment
The following provider types are required to complete and submit a Self- Assessment and Transition Plan, as necessary, demonstrating their agency's compliance:

Residential Providers:
- 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)

Non- Residential Providers:
- Facility Based Day
- Community Based Day
- In-home Day
- Supported Employment
- Adult Day Facility

Self-Assessment
Each provider will receive a link to the self-assessment tool. The assessment questions are in Yes/No format. Each question answered 'Yes' should have corresponding documentation to serve as evidence of compliance. Each question answered 'No' should be included in the Transition Plan.

Providers will use a 'Crosswalk' in order to identify which documents are associated with each question on the Provider Assessment in Wufoo.

State Transition Plan
HCBS providers will complete their self-assessment and provide their reviewing MCO with evidence that they are following the new rules, or what they will change to begin following the new rules.

MCOs will review the evidence, ask for more proof if needed, or a plan if changes are needed to comply with the new rule. If a provider is unwilling or unable to comply with the new rules, they can no longer provide HCBS - People served will transition to new providers

http://www.tn.gov/tenncare/forms/NewRulePresentationforConsumersFamilies.pdf

Electronic Visits Verification (EVV) Updates

Middle Tennessee Implementation Provider Reminders (Participating and Non-Participating)
What changes took place?

April 2015

TennCare transitioned from two MCOs in each Grand Region of the state to three MCOs Statewide. Since Jan. 1, 2009, United Healthcare and BCT have operated in East and West Tennessee and UnitedHealth Care and Amerigroup have operated in Middle Tennessee.

Jan. 1, 2015, UnitedHealth Care, BCT and Amerigroup began operating statewide. This offers more options to our CHOICES members. Since three MCOs are available to members, remember some members transitioned to a new MCO to ensure even distribution of enrollment.

Date Reminders

Feb. 13, 2015:
Notices were sent to Phase 2 transitioning members informing them of their new MCO assignments.

Feb. 14, 2015:
Phase 2 members were sent a notice reminding them of this date to request to stay with their current MCO. Members also received information on how to request to stay, which was included with their notice. Members continue to be enrolled in their current MCO until Mar. 31, 2015. Members were also advised that they can only transition to their new MCO or request to stay with their current MCO; they cannot request to move to another MCO. They will be able to choose any MCO during their annual open enrollment period.

April 1, 2015:
Members who were sent notices and did not request to stay with their current MCO transitioned to their new MCO. 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.

May 15, 2015:
Members who transitioned to a new MCO have until this date to request to change back to their previous MCO. There is information on how to request to change back to their previous MCO included with their notice. This is not a hard deadline. Members can still opt out after this reassignment date.

Continuity of Care for CHOICES Members

Starting April 1, 2015, CHOICES members moved to their NEW MCO. Until at least April 30, 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 April 30, 2015? If you are currently not contracted with BCT and wish to do so, contact the Provider Relations Team at ChoicesProviderRelations@bcbst.com.

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 for your preset schedules.
- Please remember to check the member's eligibility via the client general screen to ensure the member is still eligible to receive services with BCT as the members eligibility could change due to the opt out period.
- If you have issues with your authorizations as it relates to the transition of members you currently services, please notify BCT via ProviderAuthIssues_gm@bcbst.com. Be sure to include the member's first and last name, member identification number, authorizations number, and specific details related to your authorization issue.

BlueCare Tennessee

CHOICES
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April 2015

Provider Monthly Education

BCT CHOICES Provider Relations will host Monthly Educational Provider Webinars and Quarterly Provider Summit Meetings. For your convenience the Webinars will be facilitated as WebEx Presentations and Provider Summit meetings will be hosted throughout the state. Notification of these important educational opportunities will be submitted to each BCT CHOICES Provider and via email and/or fax blasts. Please be on the lookout for these correspondences.

To ensure we have the most up to date provider contact information, please contacted to your assigned Provider Network Manager.

Webinar	Subject
April 28, 2015	Credentialing, Re-credentialing and provider site visits
May 28, 2015 (*subject to change)*	Nursing Facilities (Enhanced Respiratory Care, Claims Submissions)
July 28, 2015	HCBS New Setting Rule
Aug. 27, 2015	CHOICES Program (including CLS)
Sept. 24, 2015	To be determined (TBD)
Oct. 27, 2015	TBD

Quarterly Provider Summit Meetings	Location	Topics
June 25, 2015	Memphis, TN	CHOICES Program (including New Setting Rule, and CLS)
Nov. 17, 2015	TBD	TBD

Provider Network Managers

South Eastern Region:
Bianca Merrell
Bianca_Merrell@bcbst.com
(423) 535-5900

East and North Eastern Region:
Jonathan Miller
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(423) 854-6001

South West and South East lower Middle Region:
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North West and North East Middle Region
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North West and South West Region
Sherry Metts
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(901) 544-2459

North East and South East West Region:
Ashley McDonald
Ashley_McDonald@bcbst.com
(901) 544-2136

Contact Information

BCT 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