



of Tennessee

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801 Pine Street  
Chattanooga, TN 37402

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BlueCare®  
TennCareSelect

## Important Clarification to BlueCare and TennCareSelect Medical Necessity Review Requirements

January 2006

Beginning Dec. 1, 2006, the new Medical Necessity Rule 1200-13-16 became effective. In making a medical necessity determination, Volunteer State Health Plan Inc., (VSHP) will consider a recommendation, order, or prescription for a covered medical item or service from a treating physician or other treating health care provider. A recommendation, order or prescription shall be based on a thorough, up-to-date assessment of the enrollee's medical condition with careful consideration of all required medical necessity criteria. Upon request from VSHP or the Bureau of TennCare for purposes of making an individualized medical necessity determination, the treating physician or other health care provider must provide information and/or documentation supporting the need for the recommended medical item or service. VSHP will attempt to obtain this information either verbally or via fax. Additionally, VSHP will request the treating physician or other health care provider to provide a written explanation and/or medical documentation as to why a proposed less costly alternative is not believed to be adequate to address the enrollee's medical condition. If the requested supporting medical documentation is not provided, VSHP will be unable to approve the service.

All requests for private duty nursing (PDN) and home health services (HHS) require Prior Authorization to establish medical necessity. VSHP will require providers seeking Prior Authorization for these services to provide the frequency, scope and duration of the requested service. Specific instructions must follow the request, i.e., a blanket prescription for 24/7 PDN will not be sufficient. Private duty nursing and home health services are described as:

**Home Health Services** ordered by a treating physician and provided by a licensed HH agency pursuant to a plan of care at an enrollee's place of residence, part-time or intermittent nursing services, HH aide services or physical, occupational and speech therapies and audiology services. HH providers may only provide services that have been ordered by the treating physician, are pursuant to a plan of care and may not provide other services such as general child care services, cleaning services or preparation of meals. For this reason and to the extent that home services are provided to a person under age 18 years, a responsible adult (other than the HH care provider) must be present at all times in the home during provision of HHS. If a responsible adult is not present the care must still be provided and VSHP should be notified immediately if this occurs.

**Private Duty Nursing** services are for recipients who require continuous skilled nursing care (eight or more hours during a 24-hour period), provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician.

Prior Authorization requests for HHS or PDN must contain the following information:

- Name of physician prescribing the service(s);
- Specific information regarding the patient's medical condition and any associated disability that creates the need for the requested service(s);
- Specific information regarding the service(s) the nurse or aide is expected to perform including the frequency with which each service must be performed (e.g., tube feeding patient, bathing, administering medications, catheterization, wound dressing);
- Total time period the services are anticipated to be medically necessary by the treating physician; and
- Nursing notes for private duty nursing and home health services rendered.

A PDN/HH request form is enclosed for use when requesting Prior Authorization for these services.

Additional information on Medical Necessity and the TennCare Rules can be found on the Bureau of TennCare's Web site, [www.tennessee.gov/tenncare/providernew.htm](http://www.tennessee.gov/tenncare/providernew.htm).

If you have questions about the information in this mailing, call BlueCare at 1-800-468-9736 or TennCareSelect at 1-800-276-1978, Monday through Friday, 8 a.m. to 6 p.m. (ET).

Thank you for your continued support of the TennCare program.

Enclosure



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<b>This information is:</b>
<input type="checkbox"/> <b>Public</b> <input type="checkbox"/> <b>Internal</b> (BlueCross BlueShield of Tennessee Use Only) <input type="checkbox"/> <b>Confidential</b> <input type="checkbox"/> <b>Highly Confidential</b>

### Private Duty/Skilled Nurse Visit Home Health Aide Request Form

Prior Authorization is required prior to scheduled services being rendered or within 24 hours or the next working day for emergency services. Call the UM pre-service line or complete this form and fax to:

BlueCare/TennCareSelect  
Phone: 1-800-924-7141  
Fax Number: 1-800-292-5311

<b>Extension of Services/Notification</b>
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When Prior Authorization / Notification is required and services are needed beyond the number of services authorized by Volunteer State Health Plan, Inc., you must request that the services be extended prior to the end date of the initial Prior Authorization date.

#### To be completed by Home Health Provider

BlueCare <input type="checkbox"/>	TennCareSelect <input type="checkbox"/>
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(Circle requested service)

Private Duty	Skilled Nurse	Home Health Aide
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Member Information		
Member Name (First, Middle, Last):	Member ID Number:	Member Date of Birth:
Member Address (Street, City, State, Zip):	Member Sex: Female <input type="checkbox"/> Male <input type="checkbox"/>	Diagnosis Codes:

Provider and Supplier Information		
Physician Name:	Phone Number:	Fax Number:
Provider Number:	National Provider Identifier:	Tennessee Medicaid Number:

Dates of Service for this Reference	From:	To:
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<p><b>Treatment:</b></p> <p>The following information is needed when requesting approval of new requests and to extend existing services:</p> <p>*For nursing requests, please indicate type of skilled care required and frequency of each skilled care (i.e., wound care three times a day, medication administering twice a day, tube feedings every six hours, etc.)</p> <p>*For home health aide requests, please indicate hands-on care required and frequency.</p>
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Care Giver In Home: Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of hours per day:
*Reference number if request is for extension of services:	