**Important Numbers**

**Provider Hotline for Nursing Facilities**

Did you know that Nursing Facilities have a separate provider hotline to assist with claims and billing questions? The number is 1-866-502-0056.

**Care Coordination Phone Number**

For questions concerning authorizations, care coordination, plans of care or items of that nature, please contact 1-888-747-8955. You may also send your authorization questions to the providerauthissues_gm@bcbst.com mailbox. Please keep in mind that the turnaround time for the Care Coordination mailbox is 5 business days.

**BlueCare/TennCareSelect Customer Service**

BlueCare Provider Service: 800-468-9736  
TennCareSelect Provider Service: 800-276-1978  
Automated Eligibility Line: 800-543-8607

**CHOICES Network Representatives**

Nathan Key – Middle TN  
Phone: (615) 760-8707  
Email: Nathan_Key@bcbst.com

Buffy Bass-Douglas – East TN  
Phone: (423) 535-3856  
Email: Buffy_Bass-Douglas@bcbst.com

Sheldon House – West TN  
Phone: (901) 544-2170  
Email: Sheldon_House@bcbst.com

**Authorizations**

**Advanced Technology Authorizations**

CHOICES Advanced Technology (AT) benefits are separate and in addition to medical DME benefits.

CHOICES AT authorizations are given by Care Coordination for a provider. Care Coordination will contact the AT provider to confirm a service can be provided, at that time the authorization will be given and faxed to the provider.

BlueCare medical DME benefits and authorizations must go through Care Centrex (CCX),

**Pre-Admission Evaluations (PAEs) and Eligibility**

For ALL PAEs, including those for recertification, you must enter the Medicaid Only Payor Date (MOPD) into TPAES. Failing to enter this date will result in claims denials.

Anytime a patient has a change in level of care, a new PAE is required.

**Retro Authorizations**

As retro authorizations are added to the EVV system, please remember to work and schedule them within 24 hours to avoid the authorizations disappearing in the system. For any questions on this, please contact Care Coordination or your network representative.

**Enhanced Rates for Nursing Facilities**

Please remember in order to receive enhanced rates for nursing facility services, authorization is required from care coordination. For level 1 and level 2 services being provided that do not involve enhanced services, the PAE serves as the authorization.
**CHOICES Claims & Billing**

**Timely Filing Extension**

Due to unresolved authorization issues, the timely filing limitation for CHOICES claims has been extended through April 30, 2011. Please remember, if you have dates of service that have not been previously submitted, those claims should be submitted as quickly as possible to avoid any delays in payment. If you have any questions regarding claims submission, please contact your Network Representative.

**Determining a VSHP Member**

Many times providers question which MCO the member may belong. This information can be verified by visiting www.TNAnytime.com or by viewing the member’s identification card.

All BlueCare/TennCareSelect member IDs begin with the ZECM prefix. Additionally, CHOICES will be reflected on the member’s ID card if he/she is a CHOICES member.

**CHOICES Eligibility and Liability Verifications**

Starting immediately, when you contact VSHP questioning CHOICES eligibility or liability, information will need to be submitted to VSHP for verification with the Bureau. If the information is not provided upon request, VSHP will not be able to verify the items in question with the Bureau. For example:

- If you disagree with the member’s liability, you will need to submit a copy of the member’s 2350 form. If you do not have a copy of this form, you will need to contact the Department of Human Services (DHS).

- If a member calls disagreeing with the PLA, he/she will be instructed to have his/her provider contact us.

- If you state a member is CHOICES eligible or the member has a different level of care, you will need to fax the PAE to the attention of the Customer Service Representative you speak with.

- If a member changes from Level 1 to Level 2, you are required to add the MOPD in TPAES for the date the 1B began. If the member changes from Level 2 to Level 1, the same information is required.

**Remittance Advice**

Remember: Remittance Advices should be worked upon receipt for accurate bookkeeping.

**BlueAccess**

BlueAccess is a tool available to all providers who have access to the World Wide Web. With this tool you are able to:

- View benefit limits
- Authorizations
- Access the web portal
- Review Remittance Advices
- Obtain other member specific information

To access BlueAccess, go to www.bcbst.com, register and request a shared secret. If you have any questions, please contact your Network Representative.

**Issue Reporting and Resolution**

Please allow time for your MCO to resolve any issue you have reported. Reporting issues to the Bureau creates duplicate issues and creates a delay in response time and resolution.

**Personal Emergency Response Systems (PERS)**

PERS providers should only bill for services if the member has a working landline and has a signal. If the landline is not working, the services should not be billed.

As part of best practices, monthly tests are recommended to verify clients do have a working land line.

**Web Portal Billing**

Changes to the web portal have been made to allow providers to submit claims with line items over the amount of $999.99.

If you have any questions, please contact customer service or your provider representative.
**EVV**

**EVV Training**

If at anytime your agency needs additional training on EVV, please contact your network representative. The network representative can schedule a time to come to your office and train employees on the system.

**EVV Exceptions and Missed/Late Visits**

Please remember to work your EVV exception and missed/late visit report daily. This will ensure errors are corrected more quickly.

Visits may be cancelled only if the make up visit will occur within the same week of the authorization time frame and if you do know prior to the visit taking place. This is the only instance where a visit should be cancelled. If the visit cannot be made up within the same week of the authorization time frame or if you do not know prior to the visit taking place, you must allow the visit to roll to missed and contact Care Coordination for a new authorization.

**Other Important Reminders**

**Solicitation**

By rule, the Bureau of TennCare prohibits both MCOs and Providers from soliciting TennCare enrollees in any form. TennCare payments for services related to solicitation enticement shall be considered by TennCare as non-covered service and recouped.

**Change of Ownership and Change in Demographics**

Please remember to contact your Network Representative as quickly as possible if your agency is going through a change of ownership or change in demographics.

With the change of ownership, we ask to provide at least a 60 day notice, so that new contracts can be issued and the necessary paperwork can be completed. For further questions, please contact your local network representative.

**Member Demographics**

As a reminder, anytime a member has a change in demographics (i.e. address, phone, etc.) this information must be reported to DHS in order for the system to be updated correctly. The member and/or the member’s representative must report this information.

**Contract Requirements**

**Transfer Forms**

As a CHOICES provider, you are contractually obligated to notify the MCO prior to discharge of any resident enrolled in the CHOICES program. You may begin by notifying VSHP informally through contact with the member’s Care Coordination. The Care Coordinator will assist in coordination of services needed by the member upon discharge, whether services are provided in another nursing facility or in a home and community-based setting.

If a member will need HCBS upon discharge, the services should be in place prior to the member being discharged from the nursing facility. Nursing facilities must also notify the MCO when a CHOICES member is hospitalized or when the member elects to receive hospice services in the nursing facility. The transfer form must be submitted to VSHP as the formal written notification of the member’s discharge, transfer or hospice election. The transfer form must be completed by the discharging facility and sent to VSHP. This form should be completed anytime a TennCare CHOICES member is discharged from the nursing facility including:

- Transfers to another facility
- Discharges to the hospital (even when return to the facility is expected)
- Discharges home, with or without HCBS
- Election of hospice service
- Upon a resident’s death

Please complete all sections on the form applicable to the provider. If the member is transferring to another nursing facility, the discharging or transferring facility should also complete the Receiving Nursing Facility box on the form. Incomplete forms cannot be processed. Upon receipt of the transfer form, VSHP will notify TennCare and/or DHS.

For further information on the transfer form, please contact care coordination at 1-888-747-8955, or your local network representative.
Volunteer State Health Plan (VSHP) has scheduled a CHOICES Town Hall Webinar to assist with various provider issues related to the CHOICES program. During each meeting, we will discuss in detail several issues related to CHOICES. Beginning in March, VSHP will not host Webinars in months that Town Halls are held.

To register for the Town Hall meeting, please email AncillaryNetworkDevelopment_GM@bcbst.com.

**Webinar**

Log In Information:
https://www.teleconference.att.com/servlet/AWMlogin?process=8&brand=att&AT=LO&ST=SUCCESS

Meeting Number: 734-414-0270
Meeting Code: 113365
April 27, 2011
Time: 10 a.m. to 1 p.m. ET