BlueCare Tennessee
Provider Administration Manual

PROVIDER ADMINISTRATION MANUAL

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GLOSSARY

ATTACHMENT I - Non-Emergency Medical Transportation Services

ATTACHMENT II – Tennessee Health Care Innovation Initiative
I. Introduction

Volunteer State Health Plan, Inc., dba BlueCare Tennessee provides a fully integrated health offering including behavioral health services for BlueCare and TennCare Select Members. BlueCare Tennessee is a Health Maintenance Organization and wholly owned subsidiary of BlueCross BlueShield of Tennessee, Inc. and an independent licensee of the BlueCross BlueShield Association. BlueCare and TennCare Select are products underwritten by BlueCare Tennessee.

BlueCare Tennessee complies with the applicable federal and state laws, rules and regulations and does not discriminate against Members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a Member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call 1-800-468-9698 for BlueCare, 1-888-325-8386 for CoverKids or 1-800-263-5479 for TennCare Select. For TTY help call 771 and ask for 888-418-0008.

Information about the civil rights laws can be found at http://www.bcbst.com/ or from the Department of Health and Human Services at http://www.hhs.gov/ocr/index.html.

This BlueCare Tennessee Provider Administration Manual ("Manual") contains comprehensive information regarding BlueCare® and TennCare Select operating policies and procedures. The information contained in this Manual applies to Providers who care for BlueCare and/or TennCare Select Members ("Members"). The requirements, policies and processes defined in this Manual are a contractual obligation as stipulated in BlueCare Tennessee’s BlueCare and/or TennCare Select Provider Agreements.

BlueCare Tennessee will have in place, written policies and procedures for the selection and retention of Providers. These policies and procedures shall not discriminate against particular providers that service high risk populations or specialize in conditions that require costly treatment.

BlueCare Tennessee will not discriminate for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. BlueCare Tennessee’s ability to credential Providers as well as maintain a separate network and not include any willing Provider is not considered discrimination.

BlueCare Tennessee will not discriminate against Providers and entities in accordance with the federal prohibition against discrimination as provided for under the collective “federal health care Provider conscience protection statutes,” referenced individually as the Church Amendments, 42 U.S.C. § 300a–7, section 245 of the Public Health Service Act, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2010, Public Law 111–117, Div. D, Sec. 508(d), 123 Stat. 3034, 3279–80.”

Furthermore, no person shall be subjected to any form of retaliation to include, threats, coercion, intimidation or discrimination as a result of filing a complaint, testifying, assisting or participating in an investigation, proceeding or hearing.

Changes to this Manual will be communicated to Providers at least thirty (30) days prior to implementation (excludes medical policy changes driven by new technology). Such changes are communicated using one or more of the following resources:

- BlueAlert Monthly Provider Newsletter
- Individual Provider Mailings
- Quarterly Provider Manual Updates
- Bi-Monthly CHOICES Provider Newsletter

Rev 09/17
A. BlueCross BlueShield of Tennessee Statement of Purpose

➢ BUSINESS
Our Business is financing affordable health care coverage.

➢ PURPOSE
Our Purpose is Peace of Mind.

➢ LONG-TERM CORPORATE GOALS
Our Long-Term Corporate Goals are:

- Affordability
- Sustainability
- Outreach

Code of Conduct
BlueCross BlueShield of Tennessee and BlueCare Tennessee have been a part of the TennCare program since 1993. We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, the BlueCross BlueShield of Tennessee Board of Directors adopted a set of policies and Code of Conduct that applies to all BlueCare Tennessee employees, officers, contracted vendors, and members of the Board of Directors. We are willing to share our own Code of Conduct, along with related policies and procedures, with our business partners in order to relay our commitment to a corporate culture of ethics and compliance. The Code of Conduct sets an ethical tone for the organization and provides guidelines for how we and our business partners are expected to conduct business.

We encourage suppliers and third parties with which we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud. More information regarding fraud, waste and abuse education and training can be found on the Centers for Medicare & Medicaid Services (CMS) website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers, Suppliers, and Third Parties”. The primary focus of these sections is to help ensure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our professional responsibilities should be avoided. You may review the BlueCare Tennessee Code of Conduct in its entirety online at https://bluecare.bcbst.com/forms/VSHPCodeofConduct.pdf.

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation or fraud, waste or abuse, please call the Confidential Compliance Hotline, 1-888-343-4221 or e-mail compliancehotline@bcbst.com.

B. Description of Health Plans and Health Plan Sub-Programs

BCBST has a long-standing commitment to provide excellent service to the people who depend on us. The increased emphasis at both federal and state levels for establishing National Health Care
Reform resulted in the State of Tennessee’s introduction of the TennCare Program. BlueCross BlueShield of Tennessee, through BlueCare Tennessee, is only one of the Managed Care Organizations (MCOs) administering the TennCare Program in the State of Tennessee.

1. BlueCare Tennessee operates two TennCare Program Health Plans. They are:

1.1 BlueCare
BlueCare is a product underwritten by BlueCare Tennessee and provides medical care for its TennCare Members. BlueCare strives to ensure Members receive the highest quality of care in the most cost-effective manner.

BlueCare is a Primary Care Practitioner (PCP)-driven HMO network focusing on PCPs providing appropriate care to Members in accordance with established clinical guidelines offering its Members and Providers programs in medical management, quality improvement, education and development, as well as quality customer service. The customer service areas are designed to provide efficient access and assistance to our Providers and Members.

1.2 TennCare Select
TennCare Select is the State’s self-insured TennCare Health Maintenance Organization that is available to select TennCare Enrollees effective July 1, 2001. It is administered by BlueCare Tennessee, a subsidiary of BlueCross BlueShield of Tennessee, and has the same benefits as all other MCOs. Enrollees cannot choose TennCare Select; only the Division of TennCare can enroll Members. Some of the groups identified by the State, as “select populations” are children whose eligibility category is SSI (children receiving Social Security Insurance benefits); children who are in the custody of the state; and children who are in an institutional eligibility category. TennCare Select serves as the backup program to handle overflow in a geographic area in which other TennCare MCOs do not provide adequate capacity to serve all Enrollees in the region.

In addition to serving select populations, TennCare Select is the State’s safety net network. TennCare Select was created by the state in response to the Provider community’s request that a safety net be created for the TennCare Program. TennCare Select reduces disruptions in claims payment and cash flow in the event MCOs experience future problems.

As administrator, BlueCross BlueShield of Tennessee manages the Provider network, processes claims and prior authorizations, and performs related functions. TennCare Select Enrollees are entitled to all TennCare Covered Services to include behavioral health services and dental services.

The availability of TennCare Select gives the state an additional option for use in providing effective and efficient health care services to needy people in Tennessee. The availability of this option contributes to the stability of the program as a whole, while offering TennCare an opportunity to examine and evaluate new service delivery strategies. Innovations such as TennCare Select are critical in preserving TennCare’s strength and vitality for the future.

Certain TennCare Select and BlueCare Members are also eligible to receive enhanced services provided through three sub-programs. The programs are known as CHOICES, ECF CHOICES, and SelectCommunity, which the following more fully describes:

2. Enhanced Services Programs:

2.1 CHOICES Long-Term Services and Support (LTSS) – Effective 8/1/2010
TennCare implemented the CHOICES Long Term Services and Supports (LTSS), which includes care in a nursing facility, as well as care at home or in the community, known as Home and Community Based Services (HCBS). The Program promotes quality and cost-effective coordination of care for CHOICES Members with chronic, complex, and complicated health care,
social service and custodial needs. Care Coordination involves the systemic process of assessment, planning, coordinating, implementing and the evaluation of care received through a fully integrated physical, behavioral health and LTSS program to ensure the care needs of the Member are met. (See Section XXII. CHOICES in this Manual for more detailed information.)

2.2 Employment and Community First (ECF) CHOICES
The State of Tennessee’s Employment and Community First (ECF) CHOICES program is a managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program. ECF CHOICES assists individuals with disabilities in leading the life they want to live by providing supports in a person’s home or in the community. Supports that are individualized help Members obtain and maintain a job, be actively engaged in their community, and live as independently as possible. (See Section XXIII. Employment and Community First (ECF) CHOICES in this Manual for more detailed information.)

2.3 SelectCommunity (TennCare Select only)
The Division of TennCare established a TennCare Select program for certain persons with Intellectual Disabilities called SelectCommunity. The program is open primarily to persons enrolled in one of the State’s Section 1915(c) Home and Community Based Services Waiver programs for persons with intellectual disabilities, as well as Members of the former Arlington class residing in a private Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID). All SelectCommunity Members are assigned a Nurse Care Manager who serves as the Member’s and Provider’s primary point of contact for physical and behavioral health needs. (See Section XXIV. SelectCommunity in this Manual for more detailed information).

2.4 CoverKids
The State of Tennessee’s CoverKids plan provides free, comprehensive health coverage for qualifying children under age 19 years, and pregnant women. The coverage includes an emphasis on preventive health services and coverage for Physician services, hospital visits, vaccinations, well-child visits, developmental screenings, behavioral health care services, prenatal and postpartum care, pharmacy, and dental and vision care. CoverKids does not cover any chiropractic, or routine vision and routine dental care for pregnant women 19 years and older. There are low co-pays for medical services, though well-child visits and immunizations are covered at 100 percent. BlueCare Tennessee administers the CoverKids program on behalf of the State of Tennessee. Effective July 1, 2016, CoverKids is supported by the CoverKids Network. (See Section XVIII. CoverKids in this Manual for more detailed information.)

A map defining the Grand Regions and important contact numbers follow:
<table>
<thead>
<tr>
<th>BlueCare (East, West/Middle Grand Regions)</th>
<th>TennCareSelect (Statewide)</th>
</tr>
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<tbody>
<tr>
<td><strong>Member Service Line</strong> 1-800-468-9698 1-800-468-9736 1-800-357-0453 or 1-423-535-7111</td>
<td><strong>Member Service Line</strong> 1-800-263-5479 1-800-276-1978 1-800-218-3190 or 1-423-535-6399</td>
</tr>
<tr>
<td><strong>Provider Service Line</strong> 1-800-468-9698 1-800-468-9736 1-800-357-0453 or 1-423-535-7111</td>
<td><strong>Provider Service Line</strong> 1-800-263-5479 1-800-276-1978 1-800-218-3190 or 1-423-535-6399</td>
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<tr>
<td><strong>Fax</strong></td>
<td><strong>Fax</strong></td>
</tr>
<tr>
<td><strong>Prior Authorization for Medical and Behavioral Health</strong> Phone 1-888-423-0131</td>
<td><strong>Prior Authorization for Medical and Behavioral Health</strong> Phone 1-800-711-4104</td>
</tr>
<tr>
<td><strong>Fax</strong></td>
<td><strong>Fax</strong></td>
</tr>
<tr>
<td><strong>East West/Middle</strong></td>
<td><strong>Fax</strong> 1-800-292-5311</td>
</tr>
<tr>
<td><strong>Prior Authorization for DME (statewide)</strong> Phone 1-888-423-0131</td>
<td><strong>Prior Authorization for DME (statewide)</strong> Phone 1-800-711-4104</td>
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<tr>
<td><strong>Fax</strong> 1-866-325-6697</td>
<td><strong>Fax</strong> 1-866-325-6697</td>
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<tr>
<td><strong>Prior Authorization for all Home Health Services with exception of HH Therapies for children &lt;21 years)</strong> Phone 1-888-423-0131</td>
<td><strong>Prior Authorization for all Home Health Services with exception of HH Therapies for children &lt;21 years)</strong> Phone 1-800-711-4104</td>
</tr>
<tr>
<td><strong>Fax</strong> 1-423-535-5254</td>
<td><strong>Fax</strong> 1-423-535-5254</td>
</tr>
<tr>
<td><strong>Provider Initiated Notices (Behavioral Health)</strong> 1-800-859-2922</td>
<td><strong>Provider Initiated Notices (Behavioral Health)</strong> 1-800-859-2922</td>
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<tr>
<td><strong>Special Kids</strong> N/A</td>
<td><strong>Prior Authorization for Medical and Behavioral Health</strong> 1-800-215-3851 or 1-423-535-5254</td>
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<td><strong>Individual Education Plan (IEP)</strong> Fax 1-855-876-1494 or 1-423-591-9395</td>
<td><strong>Individual Education Plan (IEP)</strong> Fax 1-855-876-1494 or 1-423-591-9395</td>
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<td><strong>Utilization Management (UM) Enhanced Respiratory Care (ERC) Services for Non-CHOICES)</strong> Phone 1-888-423-0131</td>
<td><strong>Utilization Management (UM) Enhanced Respiratory Care (ERC) Services for Non-CHOICES)</strong> Phone 1-888-423-0131</td>
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<tr>
<td><strong>Fax</strong> 423-535-7790</td>
<td><strong>Fax</strong> 423-535-7790</td>
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<tr>
<td><strong>BlueCare (East, West/Middle Grand Regions)</strong></td>
<td><strong>TennCareSelect (Statewide)</strong></td>
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<td>Claims Mailing Address: <strong>BlueCare</strong>&lt;br&gt;1 Cameron Hill Circle, Ste 0002&lt;br&gt;Chattanooga, TN 37402-0002</td>
<td>Claims Mailing Address: <strong>TennCareSelect</strong>&lt;br&gt;1 Cameron Hill Circle, Ste 0002&lt;br&gt;Chattanooga, TN 37402-0002</td>
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<td><strong>CHOICES /ECF CHOICES</strong></td>
<td><strong>SelectCommunity</strong></td>
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<tr>
<td>Provider Inquiry Specialists for EVV Missed/Late Visits</td>
<td>All Inquiries</td>
</tr>
<tr>
<td>All Other Inquiries</td>
<td>Phone&lt;br&gt;1-800-292-8196&lt;br&gt;Fax&lt;br&gt;1-888-255-9175</td>
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<tr>
<td>Enhanced Respiratory Care (ERC) Services for CHOICES, Non-weaning</td>
<td>Enhanced Respiratory Care (ERC) Services for CHOICES, Non-weaning</td>
</tr>
<tr>
<td>Phone&lt;br&gt;1-888-747-8955</td>
<td>Phone&lt;br&gt;1-888-747-8955</td>
</tr>
<tr>
<td>E-mail:&lt;br&gt;<a href="mailto:CHOICESNFForms_GM@bcbst.com">CHOICESNFForms_GM@bcbst.com</a></td>
<td>E-mail:&lt;br&gt;<a href="mailto:CHOICESNFForms_GM@bcbst.com">CHOICESNFForms_GM@bcbst.com</a></td>
</tr>
<tr>
<td>Enhanced Respiratory Care (ERC) Services for CHOICES, Vent-weaning, sub-acute tracheal suctioning</td>
<td>Enhanced Respiratory Care (ERC) Services for CHOICES, Vent-weaning, sub-acute tracheal suctioning</td>
</tr>
<tr>
<td>Phone&lt;br&gt;1-888-423-0131&lt;br&gt;Fax&lt;br&gt;423-535-7790</td>
<td>Phone&lt;br&gt;1-888-423-0131&lt;br&gt;Fax&lt;br&gt;423-535-7790</td>
</tr>
<tr>
<td>Claims Mailing Address: <strong>CHOICES</strong>&lt;br&gt;1 Cameron Hill Circle, Ste 0002&lt;br&gt;Chattanooga, TN 37402-0002</td>
<td>Claims Mailing Address: <strong>SelectCommunity</strong>&lt;br&gt;1 Cameron Hill Circle, Ste 0002&lt;br&gt;Chattanooga, TN 37402-0002</td>
</tr>
<tr>
<td><strong>CoverKids</strong></td>
<td></td>
</tr>
<tr>
<td>Member Service Line&lt;br&gt;Provider Service Line</td>
<td>Claims Mailing Address: <strong>CoverKids</strong>&lt;br&gt;1 Cameron Hill Circle, Ste 0002&lt;br&gt;Chattanooga, TN 37402-0002</td>
</tr>
<tr>
<td>Prior Authorization for Medical and Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>Phone&lt;br&gt;1-888-325-8386&lt;br&gt;1-800-924-7141</td>
<td>Fax&lt;br&gt;1-800-924-7141&lt;br&gt;1-800-851-2491</td>
</tr>
</tbody>
</table>
Copayment Structure
Unless otherwise directed by TennCare, Non-Pharmacy copayment amounts, if applicable, are based on the following percentages and are reflected on the Member ID card. There shall be no out-of-pocket maximum amounts, and copayment amounts are waived for preventive services and pregnant women. (See Section XVIII in this Manual for CoverKids benefits information.)

<table>
<thead>
<tr>
<th>Poverty Levels</th>
<th>Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 99%</td>
<td>$0.00</td>
</tr>
<tr>
<td>100% - 199%</td>
<td>$10.00, Hospital Emergency Room (waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>$5.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care*</td>
</tr>
<tr>
<td></td>
<td>$5.00, Physician Specialists (including Psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>$5.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)</td>
</tr>
<tr>
<td>200% and above</td>
<td>$50.00, Hospital Emergency Room (waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>$15.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care*</td>
</tr>
<tr>
<td></td>
<td>$20.00, Physician Specialists (including Psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>$100.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)</td>
</tr>
</tbody>
</table>

*Behavioral Health Intensive Community Based Treatment (ICBT) is considered a preventive service and is not subject to Member copayment.

C. General Information

1. Interpretation Services
According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. The Executive Order, signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to BlueCare Tennessee and it is not permissible to charge a BlueCare Tennessee Member or the Member’s representative for these services.

Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any member and/or the Member’s representative who needs such services, including but not limited to, Members with Limited English Proficiency and individuals with disabilities.

Full text of Title VI of the Civil Rights Act of 1964 can be found online at www.justice.gov/crt/about/cor/13166.php.

If you, the Provider needs language assistance services in a language other than English, please call BlueCare at 1-800-468-9736 or TennCareSelect at 1-800-276-1978. Necesita ayuda con el idioma gratuita? Llame BlueCare 1-800-468-9736 y TennCareSelect 1-800-276-1978. You can also dial 711 for TRS assistance. If you require materials in alternate formats, please call us at
one of the phone numbers listed above to make such a request (e.g. provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).

As required by 42 CFR 438.206, BlueCare and its Providers and Subcontractors that are providing services pursuant to the CRA shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with Limited English Proficiency, disabilities and diverse cultural and ethnic backgrounds regardless of an enrollee's gender, sexual orientation, or gender identity. This includes the importance of network providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of BlueCross BlueShield of Tennessee Members, including TennCare Members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at http://www.lep.gov/ISpeakCards2004.pdf.

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers can not locate interpreters specializing in meeting needs of LEP clients by contacting one of the resources below:

- Language Line 1-800-874-9426
- Institute of Foreign Language 1-615-741-7579
- Hablamos Juntos website http://www.hablamosjuntos.org/

Providers may also consider:
- Training bilingual staff
- Using qualified translators and interpreters
- Utilizing telephone and video services
- Using qualified bilingual volunteers

2. Health Literacy and Cultural Competency Provider Tool Kit
Cultural Competency is an important issue facing health care Providers. It is important for organizations to have and utilize policies, trained and skilled employees and resources to anticipate, recognize and respond to various expectations (language, cultural and religious) of Members and health care Providers. More and more, health and human service Providers must operate in cross-cultural contexts. Proper preparation is necessary to effectively prevent, identify, and treat many health problems.

BlueCross BlueShield of Tennessee offers a Non-discrimination Compliance Training presentation providing health care professionals additional resources to better manage Members with diverse backgrounds. This training presentation may be accessed on the company website at https://bluecare.bcbst.com/forms/Provider%20Forms/BCT-CoverKids-Provider_Non_Discrimination_Compliance_Training.pdf.

3. Medical Referrals
Effective July 1, 2001, completion of the written referral form was eliminated for Primary Care Providers (PCPs) referring to a participating specialist or to any emergency room. PCPs are still expected to direct Members’ care and make the appropriate appointments to participating specialists. **Note:** The current written referral process is still required when referring a Member to an out-of-network Provider. (See Section VIII for out-of-network written referral instructions.)

4. Outpatient/Inpatient Behavioral Health Services
See Section XV. Behavioral Health Services of this Manual for more information on behavioral health care services. Benefits are available for clinical assessment, diagnosis, and referral, as well as inpatient and outpatient treatment for behavioral health disorders (mental illness and substance use disorders).
To arrange prior authorization call:

- **Routine Services**
  - BlueCare 1-888-423-0131
  - TennCareSelect 1-800-711-4104
  - CHOICES/ECF CHOICES 1-888-747-8955
  - SelectCommunity 1-800-292-8196
  - CoverKids 1-800-924-7141

- **Crisis Services**
  - State of Tennessee crisis hotline 1-855-274-7471

5. **Prior Authorization**

See the Utilization Management Program section of this Manual for a listing of selected services requiring prior authorization. Prior Authorization requests for physical and behavioral health services can be submitted 24-hours-a-day, 7-days-a-week via the Provider portal on [www.bcbst.com](http://www.bcbst.com). If you are not registered, go to [http://www.Availity.com](http://www.Availity.com) and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard. Providers may also request prior authorization by calling or faxing the Utilization Management Department Monday through Friday, 8 a.m. to 6 p.m. (ET). (See Important Contact Numbers later this Section for appropriate numbers.)

6. **Protected Health Information-allowable disclosures under HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule establishes national standards to protect individual’s medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care Providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members have the right to access their health information and to know how it is being protected. As such, BlueCare Tennessee requests Providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.

Federal regulations under HIPAA may require some changes in the way BlueCare Tennessee operates, however, it will not prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).

BlueCare Tennessee will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information, and BlueCare Tennessee Providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of BlueCare Tennessee Members available to each Physician and/or Health Care Professional treating BlueCare Tennessee Members and to BlueCare Tennessee, its agents, or representatives at no charge.

Privacy Regulations should not impact patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. The following offers examples of TPO, which include, but are not limited to:

- **Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for healthcare.
BlueCare Tennessee 
Provider Administration Manual

Payment - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.

Healthcare operations - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at http://www.hhs.gov/hipaa/for-professionals/faq/treatment,-payment,-and-health-care-operations-disclosures.

If you have any questions or concerns regarding privacy matters, you may contact the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail privacy_office@bcbst.com.

7. Fraud and Abuse

BlueCare Tennessee cooperates with all state and federal agencies in the investigation of fraud and abuse. As a condition of receiving any amount of payment, Provider shall comply with Section 2.20 of the Contractor Risk Agreement or the TennCare Select Agreement, as applicable, and the Federal False Claims Act, State laws (such as TCA 71-5-2601, 71-5-2603, and the Tennessee Medicaid False Claims Act (TCA 71-5-182 through 71-5-185) that pertain to civil or criminal penalties for making false claims and statements to the Government or its agencies, and the right of employees to be protected from retaliation as whistleblowers.

Provider shall have written documentation that has instructed its employees regarding these laws, including the whistleblower protection and how to report suspected fraud and abuse. Written instructions to employees shall include the following statement: “To report fraud or abuse to the Office of Inspector General (OIG) you can call toll-free 1-800-433-3982 or go online to https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. To report provider fraud or abuse to the Medicaid Fraud Control Unit (MFCU), call toll-free 1-800-433-5454.” TennCare Fraud posters may be downloaded from the OIG website at https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html.

Provider shall conduct background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, List of Excluded Individuals/Entities (LEIE), and Excluded Parties List System (EPLS). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers.

Provider shall comply with corrective action plans initiated by BlueCare Tennessee for failure to comply with its policies and procedures to prevent, detect, and report known or suspected fraud and abuse activities. Reportable fraud and abuse includes suspected fraud and abuse in the administration of the TennCare program, Provider fraud and abuse, and Member fraud and abuse. Any suspected fraud and abuse must be reported to the Tennessee Bureau of Investigation Medicaid Fraud Control Unit and the Office of Inspector General. To report any suspected fraudulent activity:

- Call BlueCross BlueShield of Tennessee Fraud and Abuse Hotline at 1-888-343-4221;
- Log onto BlueCross BlueShield of Tennessee website at http://www.bcbst.com/fraud/index.page;
- Call the OIG from anywhere in Tennessee at 1-800-433-3982; or
The following information pertains to the Federal False Claims Act:
FALSE CLAIMS ACT (Title 31, Section 3729)

Civil Liability for Certain Acts. — A person is liable under the Federal False Claims Act, who—
- Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

Civil Penalties and Damages
- Civil penalty of not less than $11,463 and not more than $22,927 (eff. 2/1/19);
- Damages of 3 times the amount of damages which the Government sustains because of the act of that person, except that the court may assess not less than 2 times the amount of damages which the Government sustains if the court finds that:
  - The person committing the violation furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the person (defendant) first obtained the information;
  - The person fully cooperated with any Government investigation of the violation; and
  - At the time the person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under Title 31 of the United States Code with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation;

Whistleblower
- Whistleblower provision
  - Individuals with original information regarding fraud involving government health care programs may file a lawsuit.
  - As used in this section, Whistleblower – means an employee who discloses suspected fraud or abuse by his/her employer to a government or law enforcement agency.
- Whistleblower successful lawsuit
  - Must meet specific legal requirements.
  - Possibly awarded 15 percent to 30 percent of total recovered.
  - Employee protected from retaliation.
- Whistleblower protection from retaliation
  - Employee must reasonably believe he/she is reporting a violation of the law.
  - Employer cannot discharge, demote, suspend, harass, or in any manner discriminate against the employee whistleblowing.
- Employer Liability for Retaliation Against Whistleblower
  - Reinstatement of job with same seniority status;
  - 2 times back pay, plus interest on back pay;
  - Litigation costs and attorneys’ fees; and
  - Any other special damages sustained by the Whistleblower.
The following information pertains to the Tennessee False Claims Act:

**TENNESSEE MEDICAID FALSE CLAIMS ACT** (Tennessee Code Annotated, Title 71, Section 5, Parts 182-185)

**Civil Liability for Certain Acts.** —

A person is liable under the Tennessee Medicaid False Claims Act, who:

- Knowingly presents, or causes to be presented, to the State a false or fraudulent claim for payment or approval under the Medicaid program;
- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the State under the Medicaid program;
- Conspires to defraud the State by getting a claim allowed or paid under the Medicaid program knowing the claim is false or fraudulent;
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State relative to the Medicaid program.

**Civil Penalties and Damages.**

- Civil penalties as follows:
  - Court Proceeding: $5,000 minimum to $25,000 maximum for each claim that violates the Tennessee Medicaid False Claims Act, or
  - Administrative Proceeding: $1,000 minimum to $5,000 maximum for each claim that violates the Tennessee Medicaid False Claims Act;
- Costs of the litigation; and
- Damages of 3 times the amount of damages the state sustains because of the act of the defendant (damages are limited to $10,000 in administrative proceedings and unlimited in court proceedings), except that 2 times the amount of damages which the State sustains may be assessed if it is found that—
  - The person committing the violation furnished officials of the State responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the person (defendant) first obtained the information;
  - The person fully cooperated with any State investigation of the violation; and
  - At the time the person furnished the State with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under the Tennessee Medicaid False Claims Act with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

**Whistleblower.**

- As used in this section, "Whistleblower" refers to the person bringing a civil action under the Tennessee Medicaid False Claims Act.
- Whistleblower successful lawsuit
  - Must meet specific legal requirements.
  - Possibly awarded 15 percent to 30 percent of total recovered.
- Whistleblower protection from retaliation
  - Employer cannot discharge, demote, suspend, threaten, harass, or in any manner Discriminate against an employee whistleblower.
- Employer Liability for Retaliation Against Whistleblower
  - Reinstatement of job with same seniority status;
  - 2 times back pay, plus interest on back pay;
  - Litigation costs and attorneys’ fees; and
  - Any other special damages sustained by the whistleblower.
TENNESSEE CRIMINAL ACTS CONCERNING MEDICAID (Tennessee Code Annotated, Title 71, Section 5, Parts 2601 AND 2603)

Criminal Liability for Certain Acts.

- **Improper Benefits.** A person commits Class E felony who knowingly obtains or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, an Improper Benefit. As used in this section, “Improper Benefit” refers to:
  - Medical assistance benefits provided pursuant to a TennCare rule, law, or regulation that the person is not entitled to receive or that are of a greater value than the person is authorized to receive;
  - Benefits the person receives as a result of knowingly making a false statement or concealing a material fact relating to personal or household income that results in the assessment of a lower monthly premium than the person would be required to pay if not for the false statement or concealment of a material fact; and
  - Controlled substances benefits the person receives by knowingly, willfully and with the intent to deceive, failing to disclose to a health care provider that the person received the same or similar controlled substance from another practitioner within the previous 30 days and the person used TennCare to pay for either the clinical visit or for the controlled substance.

- **False Claims.** An entity or person (but not an enrollee or applicant) commits a Class D felony who knowingly obtains or attempts to obtain, or aids or abets a person or entity to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, medical assistance payment under TennCare to which the entity or person is not entitled or which are of greater value than that to which the entity or person is entitled.

- **Misrepresentation of Medical Condition or Eligibility for Insurance.** An entity or person commits a Class D felony who by means of a willfully false statement regarding another person’s medical condition or eligibility for insurance to aid the person in obtaining or attempting to obtain medical assistance payments, benefits or any assistance provided under TennCare to which the person is not entitled or which are of greater value than that to which the person is authorized to receive. (“Attempting to obtain” as used in this section includes knowingly making a false claim.)

- **Obstruction of Investigation.** Any entity or person commits a Class D felony who in connection with any of the above offenses knowingly and willfully falsifies, conceals or omits by any trick, scheme, artifice, or device a material fact; makes a materially false or fraudulent statement or representation; or makes or uses a materially false writing or document.

Criminal Penalties, Restitution, and Sanctions.

- Criminal felony penalties as described above;
- Restitution to TennCare of the greater of the total amount of all medical assistance payments made to all providers, or a managed care entity, related to the services underlying the offense;
- Disqualify the person from participation in TennCare; and
- Report the person or entity to the appropriate professional licensure board or Department of Commerce and Insurance for disciplinary action.

**REQUIREMENTS FOR REPORTING FRAUD AND ABUSE.**

Persons are encouraged to report suspected fraud and abuse. Persons who have knowledge of fraud and abuse are required to report it as follows:

- **Recipient, Enrollee or Applicant Fraud.** Providers, managed care organizations, and others must notify the Office of TennCare Inspector General immediately when there is actual knowledge of TennCare recipient, enrollee or applicant fraud. Call toll-free 1-800-433-3982 or go
online https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. This obligation does not apply if the knowledge is subject to a testimonial privilege.

- **Provider Fraud.** Providers, managed care organizations, and others must notify the Medicaid Fraud Control Unit immediately when there is actual knowledge of provider fraud. Call toll-free 1-800-433-5454.

- **Failure to Report.** Any person who willfully fails to report fraud shall be subject to a civil penalty of up to $10,000 for each finding of the TennCare Inspector General.

**EDUCATION OF EMPLOYEES, CONTRACTORS, AND AGENTS – DEFICIT REDUCTION ACT OF 2005**

If Provider receives or makes annual Medicaid payments of $5 million or more then Provider meets the definition of a “covered entity” under section 6032 of the Deficit Reduction Act of 2005 and shall provide information/education to employees, contractors and agents of the Provider about false claims recovery including the following components:

1. Provide detailed information in written policies applicable to employees, contractors, and agents of the Provider about the federal False Claims Act and any State laws that pertain to civil or criminal penalties for making false claims and statements to the Government or its agents.

2. Provide detailed information about whistleblower protections under such laws, along with the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

3. These written policies must also include detailed information about the Provider’s policies and procedures for detecting and preventing fraud, waste and abuse.

4. The Provider’s employee handbook, if the “covered entity” has one, shall include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the Provider’s policies and procedures for detecting and preventing fraud, waste and abuse.

5. The Provider shall have documented instructions on how to report suspected fraud including the telephone number and person to contact within the organization. These instructions shall also tell how to report suspected fraud to external agencies such as the State of Tennessee Comptroller’s hot-line (1-800-232-5454), the Tennessee Department of Finance and Administration’s Office of Inspector General (OIG) fraud and abuse hot-line (1-800-433-3982) and the Tennessee Bureau of Investigation (TBI) Medicaid fraud hot-line (1-800-433-5454).

6. The Provider shall have procedure to follow up on suspected fraud including how they report the results of their investigation.


**8. Reporting Requirements of BlueCare Tennessee**

BlueCare Tennessee will comply with the reporting requirements established by TennCare in CRA Section 2.30.1 and will submit all reports to TennCare, unless indicated otherwise in the Agreement, according to the schedule indicated in Section 2.30.1.3.
D. Appeals Quick Reference Guide

Using the correct address to file appeals improves handling efficiency and expedites responses. The following matrix is designed to provide direction in determining the correct appeal address for both physical and behavioral health services. Reconsideration and Appeal forms can be found on the company website at [https://www.bcbst.com/providers/forms/reconsideration-and-appeals.page](https://www.bcbst.com/providers/forms/reconsideration-and-appeals.page).

<table>
<thead>
<tr>
<th>APPEAL REASON</th>
<th>APPEAL REQUESTER</th>
<th>APPEAL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Medically Necessary denials, e.g., admissions, facility continuation care, and elective surgery</td>
<td>Provider</td>
<td>BlueCare Tennessee/BCBST Government Services</td>
</tr>
<tr>
<td><em>(See Section VIII. L. Utilization Management Provider Appeals Process)</em></td>
<td></td>
<td>UM Appeals Department</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Cameron Hill Circle Ste 0020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37402-0020</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax Number 1-888-357-1916</td>
</tr>
<tr>
<td>Issues regarding claims, accounts receivable, denials for non-covered services, denials for no referral, member benefits, Member eligibility, and referral status</td>
<td>Provider</td>
<td>BlueCare Tennessee/BCBST Provider Appeals Coordinator</td>
</tr>
<tr>
<td><em>(See Section XII. A. Administrative Inquiry)</em></td>
<td></td>
<td>Provider Network Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Cameron Hill Circle Ste 0007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37402-0007</td>
</tr>
<tr>
<td>Denials that are upheld through the above noted processes may be submitted through the Provider Dispute Resolution process.</td>
<td>Provider</td>
<td>BlueCare Tennessee/BCBST</td>
</tr>
<tr>
<td><em>(See Section XII. B. Provider Dispute Resolution Procedure)</em></td>
<td></td>
<td>1 Cameron Hill Circle Ste 0039</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37402-0039</td>
</tr>
<tr>
<td>Delays, denials, reduction, suspension, or termination of services for Members</td>
<td>Member</td>
<td>TennCare Solutions</td>
</tr>
<tr>
<td><em>(See Section VII. E. Member Appeals)</em></td>
<td></td>
<td>PO Box 593</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nashville, TN 37202-0593</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax Number 1-888-345-5575</td>
</tr>
</tbody>
</table>
## E. Important Contact Information

<table>
<thead>
<tr>
<th>Contact</th>
<th>Toll Free/Local Number</th>
<th>Address/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Enrollment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Information</td>
<td>1-800-924-7141</td>
<td>Contracting e-mail: <a href="mailto:Contracts_Regs_GM@bcbst.com">Contracts_Regs_GM@bcbst.com</a></td>
</tr>
<tr>
<td>Credentialing</td>
<td>Direct Line 1-800-357-0395</td>
<td>Questions related to paperwork status, the enrollment process, contract effective dates, acceptance letters, if a Provider has been loaded into our system, claims issues, Tax, when a change form should be used vs a PER, demographic changes (non-par), returned mail or checks. To submit Provider change forms, e-mail: <a href="mailto:PNS_GM@bcbst.com">PNS_GM@bcbst.com</a> To provide supporting documentation for a submitted enrollment form or for online enrollment process issues, e-mail: <a href="mailto:ProviderSupport@bcbst.com">ProviderSupport@bcbst.com</a> Credentialing e-mail: <a href="mailto:credentials@bcbst.com">credentials@bcbst.com</a> eBusiness e-mail: <a href="mailto:eBusiness_Service@bcbst.com">eBusiness_Service@bcbst.com</a></td>
</tr>
<tr>
<td>Provider Service Lines:</td>
<td></td>
<td>Available Monday - Friday (except between 7 p.m. and 9 p.m. when eligibility information is being updated) and Saturday and Sunday from 8 a.m. to 4 p.m. The system is not available on Thanksgiving Day or Christmas Day</td>
</tr>
<tr>
<td>BlueCare</td>
<td>1-800-468-9736</td>
<td></td>
</tr>
<tr>
<td>TennCareSelect</td>
<td>1-800-276-1978</td>
<td></td>
</tr>
<tr>
<td>CHOICES/ECF CHOICES</td>
<td>1-800-468-9736</td>
<td></td>
</tr>
<tr>
<td>SelectCommunity</td>
<td>1-800-292-8196</td>
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</tr>
<tr>
<td>CoverKids</td>
<td>1-800-924-7141</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Toll Free/Local Number</td>
<td>Address/Description</td>
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<tr>
<td>Provider Relations:</td>
<td></td>
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</tr>
<tr>
<td>Chattanooga</td>
<td>423-535-6307</td>
<td>BlueCare Tennessee/BCBST</td>
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<tr>
<td></td>
<td></td>
<td>ATTN: Provider Relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Cameron Hill Circle, 2G</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37402</td>
</tr>
<tr>
<td>Johnson City/Knoxville</td>
<td>865-588-4640</td>
<td>BlueCare Tennessee/BCBST</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ATTN: Provider Relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>801 Sunset Drive, Bldg C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Johnson City, TN 37604</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Memphis/Jackson</td>
<td>1-855-646-9258</td>
<td>BlueCare Tennessee/BCBST</td>
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<tr>
<td></td>
<td></td>
<td>ATTN: Provider Relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>85 N. Danny Thomas Blvd-2MD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Memphis, TN 38103</td>
</tr>
<tr>
<td>Nashville</td>
<td>1-855-646-9258</td>
<td>BlueCare Tennessee/BCBST</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ATTN: Provider Relations</td>
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<tr>
<td></td>
<td></td>
<td>3200 West End Ave., Ste 102</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nashville, TN 37203</td>
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<tr>
<td>NurseLine:</td>
<td></td>
<td>Direct Line available 24-hours-a-day, 7-days-a-week</td>
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<td>Health Information and Education</td>
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<td>Health Care Counseling</td>
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<tr>
<td></td>
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<td>Telephone Triage</td>
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<tr>
<td>BlueCare CoverKids</td>
<td>1-800-262-2873</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-866-904-7477</td>
<td></td>
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<tr>
<td>Health Information Tape Library</td>
<td>Phone 1-800-999-1658</td>
<td>Health Information Library available 24-hours-a-day.</td>
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<tr>
<td>TennCare Solutions Unit</td>
<td>Phone 1-800-878-3192</td>
<td>TennCare Solutions Unit</td>
</tr>
<tr>
<td></td>
<td>Fax 1-888-345-5575</td>
<td>P.O. Box 593</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nashville, TN 37202-0593</td>
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<tr>
<td>TennCare Pharmacy Program (Prior Authorizations)</td>
<td>Phone 1-866-434-5524</td>
<td>Magellan Pharmacy Solutions</td>
</tr>
<tr>
<td></td>
<td>Fax 1-866-434-5523</td>
<td>Provider Relations</td>
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<td></td>
<td></td>
<td>11013 West Broad Street, Ste 500</td>
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<tr>
<td></td>
<td></td>
<td>Glen Allen, VA 23060</td>
</tr>
<tr>
<td>Dental</td>
<td>Phone 1-855-418-1623</td>
<td>DentaQuest</td>
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<td></td>
<td></td>
<td>465 Medford Street</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boston, MA 02129</td>
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<tr>
<td>Contact</td>
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<tr>
<td>eBusiness Solutions Technical Support (Availity, Electronic billing, EFT, ERA)</td>
<td>Phone 1-423-535-5717 Option 2</td>
<td>BlueCross BlueShield of Tennessee eBusiness Solutions 1 Cameron Hill Circle Chattanooga, TN 37402</td>
</tr>
<tr>
<td>Fraud &amp; Abuse Hotline</td>
<td></td>
<td>To report suspected fraudulent activity.</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>Phone 1-888-343-4221</td>
<td></td>
</tr>
<tr>
<td>Division of TennCare</td>
<td>Phone 1-800-433-3982</td>
<td></td>
</tr>
<tr>
<td>Tennessee Bureau of Investigation Medicaid Fraud Control Unit</td>
<td>Phone 1-800-433-5454</td>
<td></td>
</tr>
<tr>
<td>Office of Inspector General</td>
<td>Phone 1-800-433-3982</td>
<td></td>
</tr>
<tr>
<td>Population Health Management</td>
<td>Phone 1-888-416-3025 Fax 1-800-421-2885</td>
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<tr>
<td>- Care Coordination</td>
<td></td>
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<td>- Chronic Care Management</td>
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<td>- Complex Case Management</td>
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<td>- High Risk Maternity</td>
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<td>- Health Risk Management</td>
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<tr>
<td>Home Health/PDN Missed Visit Reporting Line BlueCare/TennCareSelect</td>
<td>Phone 1-800-262-2873 Fax 1-833-744-7587 1-423-535-1931</td>
<td>Report non-covered Visits greater than one (1) hour within three (3) calendar days</td>
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<tr>
<td>Transplant Case Management</td>
<td>Phone 1-800-225-8698 Fax 423-535-1994</td>
<td>Press 1 for BC/TCS</td>
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<tr>
<td>Tennessee Health Connection</td>
<td>Phone 1-855-259-0701</td>
<td>Tennessee Health Connection P.O. Box 305240 Nashville, TN 37230-5240</td>
</tr>
<tr>
<td>Inpatient/Outpatient Behavioral Health; DME Statewide; Home Health</td>
<td></td>
<td>All inpatient and some specific outpatient behavioral health care services require prior authorization. See Section VIII of this Manual for a listing of behavioral health care services requiring prior authorization.</td>
</tr>
<tr>
<td>BlueCare</td>
<td>Phone 1-888-423-0131 Fax 1-800-292-5311 Fax 1-800-919-9213</td>
<td>To arrange behavioral health services</td>
</tr>
<tr>
<td>DME Statewide</td>
<td>Phone 1-888-423-0131 Fax 1-800-292-5311</td>
<td>To arrange DME services</td>
</tr>
<tr>
<td>Home Health</td>
<td>Fax 1-423-535-5254 Fax 1-865-588-4663</td>
<td>To arrange home health services</td>
</tr>
<tr>
<td>Provider Initiated Notices</td>
<td>Fax 1-800-859-2922</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Toll Free/Local Number</td>
<td>Address/Description</td>
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<tr>
<td>Inpatient/Outpatient Behavioral Health</td>
<td></td>
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<tr>
<td><strong>TennCareSelect</strong></td>
<td>Phone 1-800-711-4104</td>
<td>To arrange behavioral health services</td>
</tr>
<tr>
<td></td>
<td>Fax 1-800-292-5311</td>
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<tr>
<td><strong>DME statewide</strong></td>
<td>Phone 1-800-711-4104</td>
<td>To arrange DME services</td>
</tr>
<tr>
<td></td>
<td>Fax 1-800-292-5311</td>
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<tr>
<td><strong>Home Health</strong></td>
<td>Fax 1-423-535-5254</td>
<td>To arrange home health services</td>
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<tr>
<td></td>
<td>Fax 1-865-588-4663</td>
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<tr>
<td><strong>Provider Initiated Notices</strong></td>
<td>Fax 1-800-859-2922</td>
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<tr>
<td><strong>Individual Education Plan (IEP)</strong></td>
<td>Fax 1-855-876-1494</td>
<td>To arrange medical/behavioral health services</td>
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<tr>
<td></td>
<td>Fax 1-423-591-9395</td>
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<tr>
<td><strong>CoverKids</strong></td>
<td>Phone 1-800-924-7141</td>
<td>To arrange medical/behavioral health services</td>
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<td></td>
<td>Fax 1-800-851-2491</td>
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<tr>
<td><strong>CHOICES/ECF CHOICES</strong></td>
<td>Phone 1-888-747-8955</td>
<td>To arrange medical/behavioral health services</td>
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<tr>
<td><strong>State of Tennessee Crisis Hotline</strong></td>
<td></td>
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<tr>
<td>Adults (18 years and older)</td>
<td>1-855-274-7471</td>
<td>To obtain immediate assistance in a crisis situation.</td>
</tr>
<tr>
<td>Children &amp; Youth (under 18 years of age):</td>
<td>1-800-690-1606</td>
<td></td>
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<tr>
<td><strong>Memphis Region</strong></td>
<td>1-866-791-9226</td>
<td>To arrange emergency crisis services</td>
</tr>
<tr>
<td><strong>Rural West TN</strong></td>
<td>1-866-791-9227</td>
<td></td>
</tr>
<tr>
<td><strong>Rural Middle TN</strong></td>
<td>1-866-791-9222</td>
<td></td>
</tr>
<tr>
<td><strong>Nashville Region</strong></td>
<td>1-866-791-9221</td>
<td></td>
</tr>
<tr>
<td><strong>Upper Cumberland</strong></td>
<td>1-866-791-9223</td>
<td></td>
</tr>
<tr>
<td><strong>Southeast TN</strong></td>
<td>1-866-791-9225</td>
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<tr>
<td><strong>Knoxville Region</strong></td>
<td>1-866-791-9224</td>
<td></td>
</tr>
<tr>
<td><strong>Northeast TN</strong></td>
<td>1-866-791-9228</td>
<td></td>
</tr>
</tbody>
</table>

Rev 06/19
### Contact

| Primary Care Provider Consultation line | 1-877-241-5575 | Staffed by Behavioral Health Peer Advisors, (Board Certified Psychiatrists). Line is available Mon – Fri, 9 a.m. to 5 p.m. (ET) |
| Non-emergency Transportation: | | |
| **BlueCare** | | Southeastrans, Inc. Osborne Office Park 5746 Marlin Rd, Ste 410 Chattanooga, TN 37411 |
| East Grand Region | 1-866-473-7563 | Non-emergency transportation services are provided for BlueCare, TennCareSelect, CHOICES, ECF CHOICES and SelectCommunity Members to and from their physical and behavioral health care services. |
| Middle Grand Region | 1-866-570-9445 | |
| West Grand Region | 1-866-473-7564 | |
| **TennCareSelect** | 1-866-473-7565 | |
| Statewide | | |
| **CHOICES/ECF CHOICES** | 1-888-747-8955 | |
| **SelectCommunity** | 1-800-292-8196 | |

**Note:** Effective July 2015, BlueCare and TennCareSelect implemented an automated phone and web-based Provider Satisfaction Survey. After the Provider receives the requested information, authorization confirmation, or reference number, this survey allows the Provider the opportunity to rate the quality of service provided.
II. How to Identify a BlueCare Tennessee Member

(This section does not apply to CoverKids. See Section XVIII. CoverKids in this Manual.)

A. Determining Eligibility

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population (TennCare Standard).

**TennCare Medicaid**
As provided in state rules and regulations. TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged, and individuals with disabilities.

**TennCare Standard**
TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES 217-Like HCBS Group, as well as an expanded population of children.

Additional detail about eligibility criteria for covered groups is provided in the TennCare Rules and Regulations available on the state’s website, [www.tn.gov/tenncare](http://www.tn.gov/tenncare).

If BlueCare Tennessee verifies eligibility of an individual who is subsequently determined to have been ineligible at the time services were rendered, BlueCare Tennessee shall recover payments made to BlueCare Tennessee Providers for services rendered to that Member.

**Presumptive Eligibility for Breast/Cervical Cancer Group**
Temporary Medicaid coverage is extended to uninsured women under age 65 who have been determined to have breast or cervical cancer, including precancerous conditions, through the Centers for Disease Control screening process. Presumptive eligibility grants full TennCare benefits for 45 days, beginning on the day the woman is enrolled in the presumptive eligibility program.

The presumptive eligible member will be given a Presumptive form completed by the Health Department to use as a temporary ID card until the MCO chosen can provide one. This form will state the effective and termination date of the 45-day coverage period as well as the MCO chosen. In order to continue TennCare coverage beyond the 45-day period, the woman must complete an application with the Department of Human Services (DHS), or apply online at [www.HealthCare.gov](http://www.HealthCare.gov). This site will take them to either the Marketplace or to TennCare to be approved for continued enrollment in TennCare.

When a BlueCare or TennCareSelect presumptive eligible member presents to the office of a participating Practitioner covered services should be rendered. Practitioners should send their patients who have been diagnosed with breast or cervical cancer and without health insurance to the local health department to apply for presumptive eligibility.

**Presumptive Eligibility for Maternity**
See Section IX. OB Services for information regarding presumptive eligibility for pregnant women.

**Verifying Eligibility**
BlueCare Tennessee strongly recommends Providers conduct an eligibility search on all patients to identify any existence of TennCare coverage prior to rendering services. TennCare eligibility can be verified using the Division of TennCare’s online eligibility services at [https://www.tn.gov/tenncare/providers/verify-eligibility.html](https://www.tn.gov/tenncare/providers/verify-eligibility.html) or by calling 1-800-852-2683. Providers may also call BlueCare at 1-800-468-9736 or TennCareSelect at 1-800-276-1978. Eligibility information for undocumented aliens can be located on the TennCare Online Eligibility Services (formerly Tennessee Anytime) website by using the temporary identification number and date of birth. Providers can call the BlueCare or TennCareSelect Provider Service lines above to verify eligibility also. Medical emergency services (inpatient and outpatient), along with maternity services are the only benefits available to the undocumented alien population. Maternity benefits consist of labor and delivery services only.
B. Member Liability

Federal and Tennessee law prohibit Providers participating in the TennCare program from billing or attempting to collect payment from TennCare Enrollees for TennCare-authorized and/or Covered Services other than applicable copayments and special fees permitted by TennCare Rules and Regulations found at https://www.tn.gov/content/dam/tn/tenncare/documents2/pro08001.pdf. As directed by the Division of TennCare Office of Contract Compliance and Performance, BlueCare Tennessee, as a TennCare Managed Care Contractor, shall ensure that the participating Provider ceases all actions to bill a BlueCare, TennCare Select, CHOICES, or ECF CHOICES Enrollee by issuing a “Cease to Bill Notice” to the Provider. In addition, the Provider must confirm, in writing, to BlueCare Tennessee that he/she has stopped or agrees to stop billing the TennCare Enrollee.

Providers may seek payment from BlueCare Tennessee Members only in the following situations:

1. If the services are not covered by the TennCare program, and prior to providing the services, the Provider informed the Enrollee the services were not covered. The Provider is required to inform the Enrollee of the non-Covered Service and have the Enrollee acknowledge the information. Regardless of any understanding worked out between the Provider and the Enrollee about private payment, once the Provider bills an MCO for the service that has been provided, the prior arrangement with the Enrollee becomes null and void without regard to any prior arrangement worked out with the Enrollee; or

2. If the Enrollee’s TennCare eligibility is pending at the time services are provided and the Provider informs the Enrollee they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the Provider and the Enrollee about private payment, once the Provider bills an MCO for the service that has been provided, the prior arrangement with the Enrollee becomes null and void without regard to any prior arrangement worked out with the Enrollee; or

3. If the Enrollee’s TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost share amounts must be refunded when a claim is submitted to an MCO if the Provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim).

4. If the services are not covered because they are in excess of the Enrollee’s hard benefit limit and the Provider complies with applicable TennCare rules and regulations.

Providers may not seek payment from BlueCare Tennessee Members when:

1. The Provider knew or should have known about the Member’s TennCare eligibility or pending eligibility prior to providing services.

2. The claim(s) submitted to BlueCare Tennessee for payment was denied due to Provider billing error or a BlueCare Tennessee claims processing error.

3. The Provider accepted BlueCare Tennessee assignment on a claim, and it is determined that a primary plan paid an amount equal to or greater than the TennCare allowable amount.

4. The Provider failed to comply with TennCare policies and procedures or provided a service, which lacks Medical Necessity or justification.

5. The Provider failed to submit or resubmit claims for payment within the time periods required by BlueCare Tennessee.
6. The Provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the Member presents another form of insurance, the Provider must determine whether the Member is covered under TennCare.

7. The Provider failed to inform the Member prior to providing a service not covered by TennCare that the service was not covered and the Member may be responsible for the cost of the service. Services, which are non-covered by virtue of exceeding limitations, are exempt from this requirement.

8. The Member failed to keep a scheduled appointment(s).

9. The Provider failed to follow Utilization Management (UM) notification or prior authorization policies and procedures.

C. ID Card

Each BlueCare and TennCareSelect Member receives a plastic Member ID card reflecting his/her Primary Care Provider (PCP) name and effective date. A new ID card is issued each time the Member changes his or her PCP.

If the Member is Medicare/Medicaid dual eligible, the ID card will reflect the following eligibility information:
- Medicare Part A Only – PCP’s name (reflected in PCP field) and effective date
- Medicare Part B Only - “Medicare/Medicaid” (reflected in PCP field)
- Part A and Part B - “Medicare/Medicaid” (reflected in PCP field)

Note: Medicare/Medicaid dual-eligible Members with Part B or Part A and B are not required to seek care from a PCP for their care, except for Medicare non-Covered Services that are BlueCare/TennCareSelect-covered.

The BlueCare Tennessee ID card provides the following information:
- Member name;
- Member ID number;
- Assigned Primary Care Provider;
- Member liability (if applicable);
- Member’s Date of Birth;
- Prior authorization information;
- TennCare eligibility classification:
- Benefit level; and
- Copayment (if applicable)

Sample copy of the BlueCare Member ID card (Standard or Medicaid) follows:

![Sample copy of the BlueCare Member ID card](image-url)
Sample copy of the TennCareSelect Member ID card (Standard or Medicaid) follows:

If a Member presents without his or her ID card, Providers should check eligibility by:

- Checking his or her most recent online BlueCare/TennCareSelect Member Listing (if a Primary Care Provider);
- Calling the appropriate BlueCare Tennessee Provider Service line Monday through Friday, 8 a.m. to 6 p.m. (ET):
  - BlueCare 1-800-468-9736
  - TennCareSelect 1-800-276-1978
- Calling the Automated Information lines (numbers above are also available 24-hours-a-day, 7-days-a-week for self-service use during or after business hours);
- Accessing e-Health Services® via Availity on the company websites, www.bcbst.com or http://bluecare.bcbst.com;
- Accessing the online eligibility verification link on the State of Tennessee website, https://www.tn.gov/tenncare/providers/verify-eligibility.html; or
- Calling the Division of TennCare at 1-800-852-2683.

**Benefit Levels are defined as:**

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<thead>
<tr>
<th>BPI</th>
<th>Eligibility Description</th>
<th>Pharmacy Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>A child under age 21, who does <strong>NOT</strong> have Medicare. (May include CHOICES – Nursing Facility Only)</td>
<td>As Medically Necessary</td>
</tr>
<tr>
<td>B</td>
<td>A TennCare Medicaid adult age 21 and older who does <strong>NOT</strong> have Medicare and who does not get long-term care (CHOICES)</td>
<td>5 Prescriptions (2 Brand, 3 Generic)</td>
</tr>
<tr>
<td>C</td>
<td>A TennCare Standard adult age 21 and older</td>
<td>No Pharmacy Benefits</td>
</tr>
<tr>
<td>D</td>
<td>A TennCare Medicaid adult age 21 and older who does <strong>NOT</strong> have Medicare and who is Medically Needy (Spend Down)</td>
<td>5 Prescriptions (2 Brand, 3 Generic)</td>
</tr>
<tr>
<td>E</td>
<td>A TennCare Medicaid adult age 21 and older who does <strong>NOT</strong> have Medicare and who gets long-term care other than CHOICES</td>
<td>As Medically Necessary</td>
</tr>
<tr>
<td>F</td>
<td>A TennCare Medicaid adult age 21 and older who has Medicare, and does <strong>NOT</strong> get long-term care (CHOICES),</td>
<td>No Pharmacy Benefits</td>
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### TENN CARE ELIGIBILITY CLASSIFICATION IS DEFINED AS:

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<th>Classification Type</th>
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<td>Medicare/Medicaid Dual Eligible</td>
<td>Medicaid</td>
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<td>27</td>
<td>Uninsurable/Disabled</td>
<td>Standard</td>
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<tr>
<td>37</td>
<td>Disabled Uninsured</td>
<td>Standard</td>
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<tr>
<td>47</td>
<td>Disabled Medicaid</td>
<td>Medicaid</td>
</tr>
<tr>
<td>67</td>
<td>Medicaid Other</td>
<td>Medicaid</td>
</tr>
<tr>
<td>77</td>
<td>Uninsured/Disabled with Medicare</td>
<td>Standard</td>
</tr>
<tr>
<td>87</td>
<td>Uninsured Other</td>
<td>Standard</td>
</tr>
<tr>
<td>97</td>
<td>Uninsurable</td>
<td>Standard</td>
</tr>
</tbody>
</table>

### THE POPULATIONS OF ENROLLEES WHO HAVE BEEN IDENTIFIED TO DATE FOR TENNCARESELECT INCLUDE THE FOLLOWING:

- Children who are in DCS custody;
- Children who are transitioning out of DCS custody;
- Children under 21 who are SSI eligible;
- Children receiving services in an institution or receiving HCBS under a Section 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) in order to avoid being institutionalized;
- Enrollees residing out-of-state;
- Enrollees that have not responded to TennCare’s attempts to contact and/or enrollees that are in specified Groups/Populations defined and identified by the State and agreed to by both parties;
- Persons with Intellectual Disabilities who have been defined as the Target Population for the Integrated Health Services Delivery Model; and
- Enrollees residing in areas with insufficient capacity in other TennCare MCOs.

### D. BLUECARE/TENNCARESELECT PROVIDER SERVICE LINES

Providers may verify current BlueCare Tennessee Member eligibility, claims status information, copayment amount, and the name of the Member’s assigned PCP by calling one of the following Provider Service lines, Monday through Friday, 8 a.m. to 6 p.m. (ET):

- **BlueCare**: 1-800-468-9736
- **TennCareSelect**: 1-800-276-1978
The automated information lines (numbers above are also available 24-hours-a-day, 7-days-a-week for self-service use during or after business hours).

When accessing the eligibility lines enter the numerical portions of the Member ID and follow the voice prompts. When obtaining eligibility information for a specific date of service, the service date must be entered in the appropriate format (Example: January 3, 2011 = 010311).

Access problems with the eligibility lines should be directed to the appropriate BlueCare or TennCareSelect Provider Service line listed above.

E. Electronic Data Interchange (EDI)

The Division of TennCare mandated that all TennCare managed care organizations (MCOs) electronically provide claims status and capitation payment information to its participating Providers.

BlueCare Tennessee has exceeded the mandated requirements by also implementing several other Electronic Data Interchange (EDI) processes to provide additional information via Availity, the secure section on the company websites, http://bluecare.bcbst.com/ and www.bcbst.com, through our Secure File Gateway (HTTPS) System, and through our real-time eligibility, benefits, and claim status application, BlueCORE.

Availity
Availity includes e-Health Services® (benefits, claims and authorization information), as well as access to Primary Care Provider Member rosters, Provider remittance advices, information on Patient-Centered Medical Home, and much more.

First time users must register to access these online services. To register, go to www.Availity.com and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

Secure File Gateway (SFG)
The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BlueCross BlueShield of Tennessee using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTTPS Website, <a href="https://mftweb.bcbst.com/myfilegateway">https://mftweb.bcbst.com/myfilegateway</a></td>
<td>The secure HTTPS website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>SFTP (server mftsftp.bcbst.com)</td>
<td>The SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>FTP/SSL (server mftsftp.bcbst.com)</td>
<td>The FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
</tbody>
</table>

BlueCORE
BlueCare Tennessee offers access to real-time eligibility, benefits and claim status information for TennCare Members via a secure web application called BlueCORE. Utilizing standardized electronic transactions and the Center for Affordable Healthcare (CAQH®) operating rules, Providers, software vendors, clearinghouses, and billing agents can not only obtain information across a wide range of service types in real time, but can also integrate the connection into their own processes and practice management systems.
For more information or assistance on Availity, or the Secure File Gateway (HTTPS) System, please call eBusiness Solutions at 423-535-5717, Option 2, or via e-mail at eBusiness_Service@bcbst.com. To learn more about BlueCORE, please visit http://bluecore.bcbst.com.
III. Primary Care Member Assignment

A. Primary Care Provider (PCP) Membership Listing

PCP membership listings are available electronically via Availity, the secure area on the company websites, http://bluecare.bcbst.com and www.bcbst.com. If you have not registered for Availity, go to http://Availity.com and click on “Register” in the upper right corner of the home page, select, “Providers”, click “Register” and follow the instructions in the Availity registration wizard. If you need assistance, contact our eBusiness Service Center at 423-535-5717 or e-mail Ecomm_TechSupport@bcbst.com.

There are four report selections available:

1. **Real-Time Roster**
   Lists Members currently assigned to the Provider. This report is available in real-time, listing Members assigned to the Provider at the time the report is generated.

2. **Previously Assigned Members**^*
   Lists information about Members assigned to the Provider on the previous membership listing.

3. **Members Transferred from Provider**^*
   Lists information about Members transferred to another PCP or MCO.

4. **Disenrolled Members**
   Lists information about Members who have either changed MCOs or are no longer eligible for TennCare.

*Members appearing incorrectly can easily be reassigned by e-mailing IO-BlueCarePCP_GM@bcbst.com. Please include the Member’s name, ID number, and date of birth.

^These reports are available any time, but are updated weekly and may not reflect recent changes.

The legend below describes fields on the PCP Membership Listing:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Type</td>
<td>Added Members Since Last Report, Current Members, Members Transferred From Provider, or Dropped Members</td>
</tr>
<tr>
<td>Provider ID</td>
<td>Provider ID</td>
</tr>
<tr>
<td>Line of Business</td>
<td>Line of Business (BlueCare, BlueCare Plus, TennCareSelect, or SelectKids)</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member name. The names are listed alphabetically by the first name.</td>
</tr>
<tr>
<td>Member Address</td>
<td>Address of assigned member</td>
</tr>
<tr>
<td>Phone</td>
<td>Telephone number of assigned Member</td>
</tr>
<tr>
<td>Sex</td>
<td>Member’s gender</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of birth</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>Member ID</td>
<td>ID Number of Member</td>
</tr>
<tr>
<td>Member Old ID</td>
<td>Old Member ID if applicable</td>
</tr>
<tr>
<td>Copay</td>
<td>Member’s Copay Code</td>
</tr>
<tr>
<td>EPSDT</td>
<td>TennCare Kids Visit past due</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Effective Date of Coverage</td>
</tr>
<tr>
<td>Future Disenroll Date</td>
<td>Future Disenrollment Date with PCP Termination Date</td>
</tr>
<tr>
<td>Effective With PCP</td>
<td>Effective Date with PCP</td>
</tr>
</tbody>
</table>

Rev 06/18
B. TennCareSelect Care Management Fee

In addition to routine service fees, TennCareSelect Primary Care Providers (PCPs), which include Best Practice Network and SelectCommunity are eligible to receive a Care Management Fee for services they provide to their assigned Members.

Details of the TennCareSelect Care Management Fee Program include:

1. Compensation of TennCareSelect PCPs for services rendered to improve Member health status through preventive or other risk assessment efforts, to coordinate Members’ care and for participation in BlueCare Tennessee’s Quality Improvement Program.
2. Compensation paid to TennCareSelect PCPs who reach and maintain a combined assignment of 300 BlueCare and TennCareSelect Members.
3. Compensation paid when a minimum of 300 Members are assigned, up to a maximum of 1,500 Members per TennCareSelect Primary Care Provider (TennCareSelect PCP Physician Extenders are limited to a maximum of 1,250 assigned Members and paid the care management fee accordingly).
4. TennCareSelect Care Management Fee payment eligibility is reviewed quarterly; TennCareSelect PCPs assigned less than 300 Members at the quarterly review will not receive the care management fee for the following quarter.

NOTE: Errors detected in the TennCareSelect Care Management Fee reimbursement should be documented, including PCP name, provider number and/or National Provider Identifier (NPI), phone number and provider office contact person. Mail or send by facsimile to:

BlueCare Tennessee/BCBST  
Provider Network Management, Ste 0007  
1 Cameron Hill Circle  
Chattanooga, TN 37402-0007  
Fax 423-535-5808

Eligibility List for Monthly TennCareSelect Care Management Fee

TennCareSelect PCPs eligible for the Care Management Fee (minimum 300 assigned Members) receive a monthly eligibility list with their check. The eligibility list documents all activity reflected in the accompanying check. The checks and reports are produced the 2nd or 3rd Friday of each month and mailed within 2-3 weeks. The TennCareSelect Care Management Fee paid amount is calculated Member months* x $1.54² = paid amount.

*Member months reflect current membership and any retroactivity. Providers having electronic capabilities may also access this report the second Friday of each month through BlueCross BlueShield of Tennessee’s Electronic Secure File Gateway (HTTPS) System.

¹There is no minimum enrollment criteria for Best Practice Network and SelectCommunity Providers.  
²Best Practice Network and SelectCommunity Providers receive a $10.25 pmpm fee instead of the $1.54 fee.
C. Primary Care Provider (PCP) Changes

BlueCare Tennessee Members may change PCPs after their initial assignment upon enrollment. Thereafter, Members can change their PCPs at any time, however, they should be encouraged to see the PCP listed on their identification card.

Effective August 1, 2015, Providers will not be reimbursed for services provided to Members that are assigned to other PCPs unless the following applies:

- The Member is assigned to another PCP in their group practice;
- The Member is assigned to a PCP the Provider is covering for;
- The Member is dually eligible for Medicare and Medicaid (TennCare);
- The Member is a newborn under ninety (90) days old; or
- The service is performed at a health department.

Note: Claims filed with Place of Service codes 11 and 12 will not be reimbursed unless one of the exclusions above applies.

1. PCP Change Initiated When:

- Member calls in PCP change request to BlueCare/TennCareSelect Customer Service line;
- Member mails in written PCP change request to BlueCare/TennCareSelect Customer Service;
- Member mails postage-paid PCP Change Card to BlueCare/TennCareSelect (cards are available in Member’s BlueCare/TennCareSelect Provider Directory and BlueCare/TennCareSelect Member Handbook); or
- PCP faxes Primary Care Provider Change Request form to BlueCare/TennCareSelect (only accepted if the Member is:
  * Sibling of an existing patient;
  * New to BlueCare/TennCareSelect; or
  * In need of help submitting the change.)

Completed Primary Care Provider Change Request forms need to reflect the reason for the change.

Note: PCP Change requests are made effective on the date of the request.

2. Miscellaneous PCP Assignment Information

- When a Member requests a new PCP, the Member must fall within the PCP’s stated patient accept criteria.
- If a PCP wants to change his/her patient accept criteria, he/she must submit a written request to the Provider Management Department. This request can be submitted on a Primary Care Provider Change Form or on the PCP’s letterhead.

Mail to: BlueCare Tennessee/BCBST
         Provider Management, Ste 0007
         1 Cameron Hill Circle
         Chattanooga, TN 37402-0007

Fax to: BlueCare/TennCareSelect PCP Department
        Attention: PCP Change Team
        1-888-261-9025

The PCP Change Request Form and Provider Change in Information Faxback form can be found on the BlueCare Tennessee website at https://bluecare.bcbst.com/forms/Provider%20Forms/Primary_Care_Provider_PCP_Change_Form.pdf.
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IV. Benefits

(This section does not apply to CoverKids - See Section XVIII. CoverKids in this Manual.)

A. Covered Benefits

The following sections describe the services and supplies available under BlueCare and TennCareSelect subject to the limitations and exclusions listed in this and other sections of the Manual. Covered Services must be Medically Necessary and be performed or prescribed by a Practitioner or other appropriate healthcare professional for an illness, bodily injury or pregnancy. Select services/procedures require prior authorization. (See Section VIII. Utilization Management Program in this Manual.)

Note: Where prior authorization for service(s) is required - If a Member has Medicare Part A & B, a prior authorization is not required as long as the service is covered by Medicare. If a Member has Part A coverage only, all non-Medicare Part A services, which require prior authorization should be authorized. If a Member has Part B coverage only, all non-Medicare Part B services which require prior authorization should be authorized. Services or benefits not covered or exhausted under Medicare are reviewed for Medical Necessity and require prior authorization.

Hospital Services (Inpatient)

Bed, board and general nursing services
- A room with two or more beds
- A private room (for a private room, the maximum allowable is the hospital's most prevalent charge for a semi-private room)
- A bed in a special care unit for intensive care or critically ill patients

Ancillary Services
- Operating, delivery and treatment rooms and equipment
- Prescribed drugs
- Anesthesia, anesthesia supplies and services given by an employee of the hospital
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic services
- Patient meals

Physician Services (Inpatient)

Physician Services/Community Health Clinic Services/Other Clinic Services (Outpatient)

Hospital Services (Outpatient)

Emergency Services
- Emergency accident care – Treatment of accidental bodily injuries
- Emergency medical care – Services and supplies to treat a sudden and acute physical or behavioral health condition that requires prompt medical care
- Surgery – Surgical services and supplies and all ancillary services, including patient meals

Note: Effective July 1, 2001, non-emergency medical services no longer require a referral from the BlueCare Tennessee Member’s Primary Care Provider (PCP). Members who are eligible for BlueCare or TennCareSelect as a result of Medicaid eligibility pay no fee for the use of the hospital emergency room. All other BlueCare Members are required to pay a $10.00 or $50.00 Copay depending on the Member’s income, each time the hospital emergency room is used. The Copay amount is collectable from the non-Medicaid Member by the facility at the time service is rendered. (Copay amount is waived if Member is admitted.)

Rev 09/16
Kidney Dialysis Services
Kidney dialysis clinic services and supplies for dialysis are paid on the same basis as for those provided by a hospital.

Special Services
Outpatient tests and studies required for a scheduled admission as an inpatient are usually reimbursed as part of the surgical global fee.

Surgical/Medical Services

Surgery
- Must be done by a licensed surgeon and is Medically Necessary

Special Surgery
- Transplant services (not determined Investigational) when Medically Necessary, Covered by Medicare, and consistent with the accepted mode of treatment for which the transplant procedure is performed. BlueCare Tennessee will not provide benefits for an artificial heart, lung, liver, pancreas, or any other artificial organ or associated expense.
- Reconstructive surgery to restore bodily function or correct deformity (benefits are only for problems caused by disease, injury, birth or growth defects or previous treatments)
- Sterilization services for the treatment or operation for the purpose of rendering a BlueCare Tennessee Member (at least 21 years of age) permanently incapable of reproducing

Note: STERILIZATION IS SUBJECT TO SPECIFIC CONDITIONS. Benefits will be provided for such services only if the Member is mentally competent and not institutionalized. The STERILIZATION CONSENT FORM must be correctly completed, legible and attached to the claim when submitted to BlueCare Tennessee for payment.

Oral Surgery
- Services only provided as Medically Necessary for children under age 21 years
- Removal of impacted teeth by a Practitioner
- Second or third opinion, when out-of-network referral obtained

Inpatient Medical Services
- Medical care when the Member is confined in a hospital for a condition not related to surgery, pregnancy or mental illness
- Diagnostic services
- Therapy services
- Medical care visits – intensive care; constant attendance and treatment when Member’s condition requires

Outpatient Medical Services
- Outpatient medical care that is not related to surgery, pregnancy or mental illness, except as specified
- Is not given in Member’s home
- Emergency accident care – treatment of accidental bodily injuries
- Emergency medical care – treatment of a sudden and acute medical condition that requires prompt medical care
- Home, office and other outpatient medical visits and consultations to examine, diagnose and treat an injury or illness
- Therapy services
Ambulatory Surgical Treatment Center

Benefits are provided for services and supplies in connection with an approved surgical procedure and are paid on the same basis as those provided by a hospital.

Diagnostic Services

X-rays, laboratory examinations and other diagnostic services

Newborn Services

As Medically Necessary including circumcisions performed by a Practitioner.

Physical Services

Benefits are provided for services rendered by a physiotherapist

Maternity Services

Hospital services and surgical/medical services are provided for normal pregnancy, complications of pregnancy, miscarriage and therapeutic abortion.

ABORTION AND SERVICES ASSOCIATED WITH THE ABORTION PROCEDURE SHALL BE COVERED ONLY WHERE THE LIFE OF THE MOTHER WOULD BE ENDANGERED IF THE FETUS WERE CARRIED TO TERM OR IF THE PREGNANCY IS THE RESULT OF AN ACT OF RAPE OR INCEST. A CERTIFICATE OF MEDICAL NECESSITY MUST BE COMPLETED BY THE PHYSICIAN AND ATTACHED TO THE CLAIM SUBMITTED TO BlueCare Tennessee FOR PAYMENT.

Reproductive Health Care and Family Planning Services

History, physical examination, laboratory test, advice and medical supervision related to family planning to include:

- Information and counseling
- Sex education and advice on prevention of venereal disease
- Medically-indicated genetic testing and counseling

Preventive Services

The value and performance of preventive care services is critical in the management of BlueCare or TennCareSelect; the following preventive services will be paid for all children under the age of 21 years (according to TennCare guidelines), with no copayment.

TennCare Kids Services

Benefits are provided for BlueCare Tennessee Members under the age of 21 years for:

- Pediatric screening and well-child care (“Well-child care” means a clinical check of a child in the absence of symptoms and in accordance with TennCare/American Academy of Pediatrics (AAP) guidelines for the purpose of assessing physical status and detecting abnormalities);
- Treatment of illness or injury;
BlueCare Tennessee Provider Administration Manual

- Health risk assessment;
- History, physical examination; laboratory tests, advice and medical supervision related to risk factor reduction;
- Information and counseling;
- Vision and hearing screening to determine the need for a full vision or hearing examination (for Members under the age of 21 years);
- Prenatal services; and
- Immunizations.

Prior authorization is not required for TennCare Kids screenings when performed by a participating Provider. TennCare Kids allows for the provision of services from non-participating Providers in the event a participating Provider is not available; however, prior authorization must be obtained. Preventive and TennCare Kids services shall be covered.

Ambulance Services

BlueCare Tennessee provides benefits for local ground ambulance service as Medically Necessary:

- From a Member's home or the scene of an accident or medical emergency to the nearest hospital where proper treatment can be given;
- Between hospitals;
- Between a hospital and a skilled nursing facility; and
- Transportation to a Covered Service.

Non-Emergency Medical Transportation Services (NEMT Services)

NEMT Services are provided for BlueCare and TennCareSelect Members to and from health care appointments. All non-emergency transportation should be scheduled and received prior authorization from Southeastrans, Inc. before a trip is provided. A notice of at least seventy-two (72) hours is requested prior to the Member's appointment. BlueCare Tennessee communicates to its Members how to arrange these NEMT Services via the Member handbook.

Primary Health Care Services Greater Than 30 Miles

Transportation that is greater than 30 miles from the Member's address to the following primary health care service Providers is not covered unless authorized.

- Family Practice
- Internal Medicine
- General Practice
- Pediatrician

Exceptions: Transportation that is greater than 30 miles from the Member’s address to the above-referenced Provider types may be approved under the following circumstances:

- Network Inadequacy – In the event that a Member is requesting to be transported to a Provider outside the distance requirement due to a network inadequacy, the request is reviewed by BlueCare Tennessee. If there is no network Provider available, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.
- Medical Necessity – In the event that a Member is requesting to be transported to a Provider outside the distance requirement for a medical reason, the request is reviewed by BlueCare Tennessee. If the trip meets Medical Necessity requirements and the service cannot be provided in the 30 mile distance requirement, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.
- Authorized Services – In the event that a Member is requesting to be transported to a Provider outside the distance requirement for services that have been authorized by BlueCare/TennCareSelect, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.
If BlueCare/TennCareSelect has PCPs available within 30 miles of the Member’s address, and the Member elects or chooses a PCP out of that range, BlueCare/TennCareSelect may not be responsible for transportation services. Letters detailing the above guidelines are sent to Members when a requested PCP change outside the 30 mile limit is granted. **NOTE**: These guidelines also apply to dual eligible Members.

**Specialty Health Care Services Greater Than 90 Miles**

Transportation that is greater than 90 miles from the member’s address to a specialist is not covered unless authorized.

**Exceptions**: Transportation that is greater than 90 miles from the member’s address to a specialist may be approved under the following circumstances:

- **Network Inadequacy** – In the event that a Member is requesting to be transported to a Provider outside the distance requirement due to a network inadequacy, the request is reviewed by BlueCare Tennessee. If there is no network Provider available, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.
- **Medical Necessity** – If the trip meets Medical Necessity requirements and the service cannot be provided in the 90 mile distance requirement, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.
- **Authorized Services** – In the event that a Member is requesting to be transported to a Provider outside the distance requirement for services that have been authorized by BlueCare/TennCareSelect, BlueCare Tennessee will coordinate the trip with Southeastrans, Inc.

If BlueCare/TennCareSelect has specialists available within 90 miles of the member’s address, and the Member elects or chooses a specialist out of that range, BlueCare/TennCareSelect may not be responsible for payment of transportation services. **Note**: These guidelines also apply to dual eligible members.

BlueCare Tennessee Members and/or their representatives should request NEMT Services by contacting Southeastrans, Inc., BlueCare Tennessee’s transportation broker, at the following toll-free telephone numbers, available 24-hours-a-day, 7-days-a-week:

**BlueCare**

- **East Region** 1-866-473-7563
- **Middle Region** 1-866-570-9445
- **West Region** 1-866-473-7564

**TennCareSelect** 1-866-473-7565

BlueCare Tennessee and Southeastrans are working together to provide BlueCare and TennCareSelect Members with access to non-emergency physical and behavioral health transportation using public transit systems. When a Member or health care Provider calls Southeastrans to schedule transportation, they will offer the Member bus passes if the pick-up and drop-off locations are within one-third (1/3) of a mile of the bus stop and the Member meets all requirements for riding public transit.

**Implementation effective dates**

- Aug. 1, 2009 Memphis/Shelby County
- Oct. 1, 2009 Hamilton County
- Dec. 2, 2009 Knox County, Tri-Cities, Jackson, West TN, and Middle TN (TennCareSelect Only)

Providers (or a representative of the medical facility) shall assist in arranging after-hours non-emergency transportation for BlueCare Tennessee Members after receiving Covered Services from the Provider or facility. Such assistance shall include directly contacting Southeastrans, Inc. on the Member’s behalf. In no event shall the Member be denied assistance by the Provider for scheduling after-hours transportation. Requests for non-emergency transportation during normal business hours should also be arranged through Southeastrans, Inc.

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Contract Compliance
BlueCare and TennCareSelect Members should contact Southeastrans, Inc. to request non-emergency transportation to their physical and behavioral health care services.

Southeastrans, Inc. shall comply with clear and measurable service standards of accountability as defined by TennCare and BlueCare Tennessee. When Southeastrans, Inc., on behalf of BlueCare Tennessee, determines a Transporter(s) is not meeting contractual requirements, suspension of authorization of transports may result.

Non-Compliance includes failure to submit the following documents to Southeastrans Inc., who is responsible for ensuring the Transporters and their drivers are compliant with their contractual agreement, including, but not limited to:

- Vehicle Operator Pre-Service Training
- Vehicle Operator In-Service Training
- Vehicle Operator Performance Evaluations
- Vehicle Operator Background Verifications
- Vehicle Operator License Verification
- Vehicle Mechanical Safety and Maintenance
- Valid Liability Insurance Certificate
- Business/EMS License Verification
- Monthly Driver Roster
- Monthly Vehicle Listing
- Driver Logs

BlueCare Tennessee will be responsible for addressing/resolving any Member grievances and/or appeals. Southeastrans Inc. will be responsible for addressing/resolving any Provider complaints and/or appeals.

Liability Insurance Coverage
Transporters are required to maintain liability insurance coverage as necessary to adequately protect our Members, Southeastrans, Inc. and BlueCare Tennessee. At a minimum, one million dollars ($1,000,000) combined single occurrence coverage is required from an insurance carrier licensed in Tennessee.

NEMT Transportation for Transportation Claims
Transporters are required to complete appropriately documented clean claims for TennCare benefits to Southeastrans, Inc. on an approved Trip Reimbursement Form (Driver Log), through Southeastrans Provider Web portal or other approved electronic format. Ambulance services shall submit claims on CMS-1500 claim forms with all required data elements such as, but not limited to, odometer readings reflecting the beginning and ending of the transport, etc. Any claim form, regardless of how submitted to Southeastrans, Inc. for reimbursement, will be returned if not completed accurately and in accordance with the terms of their contract before submitting it to Southeastrans Inc.

TennCare Covered Services- the health care services available to TennCare Members, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, and dental services provided through managed care contractors (MCOs), as well as institutional services and alternatives to institutional services (home and community based waiver services) provided by entities that are not MCOs. TennCare Covered Services include TennCare Kids services. For the purpose of NEMT, TennCare Covered services do not include CHOICES, or Employment and Community First CHOICES (ECF CHOICES) or 1915(c) ID waiver services. NEMT Services are defined below:

- Single Trip- transport to and/or from a single TennCare Covered Service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

- Trip Leg- One way transport from a pick-up point to a destination. A trip generally has at least two (2) trip legs.

- Urgent Trip- Covered NEMT Services for an unscheduled episodic situation in which there is no immediate threat to life or limb but the Member must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital discharge shall be an urgent trip.

(See Attachment I-NEMT of this Manual for additional non-emergency medical transportation information.)
Behavioral Health Care Services

Benefits are available for clinical assessment, diagnosis, referral, as well as inpatient and outpatient services for treatment of behavioral health disorders (mental illness, and substance use disorders). See Section XV of this Manual for specifics.

Private Duty Nursing Services

Private Duty Nursing services are for recipients who require continuous skilled nursing care (8 or more hours during a 24-hour period), provided by a registered nurse or licensed practical nurse (who is not an immediate relative) under the direction of the recipient’s Practitioner when Medically Necessary to support the use of ventilator equipment or other life sustaining medical technology when constant nursing supervision, visual assessment, and monitoring of both equipment and patient are required. Services must be prior authorized by BlueCare Tennessee Utilization Management.

Private duty nursing services are covered as Medically Necessary for children under the age of 21 years in accordance with TennCare Kids requirements. As a general rule, only a child who is dependent upon technology-based medical equipment requiring constant nursing supervision assessment, visual assessment, and monitoring of both equipment and child will be determined to need private duty nursing services. However, determinations of Medical Necessity will continue to be made on an individualized basis. A child who needs less than eight (8) hours of continuous skilled nursing care during a 24-hour period or an adult who needs nursing care but does not qualify for private duty nursing care per the requirements of these rules may receive Medically Necessary nursing care as an intermittent service under home health.

BlueCare Tennessee will only cover private duty nursing services for Members 21 years and over if the Member:

1. is ventilator dependent (for at least twelve (12)-hours-per-day); or
2. is ventilator dependent with a progressive neuromuscular disorder or spinal injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least twelve (12) hours each day in order to avoid or delay tracheostomy (requires medical review); or
3. has a functioning tracheostomy requiring suctioning and need other specified types of nursing care*.

*Member must require all of the following:

- Oxygen
- Nebulizer or cough assist
- Medication via G-tube, PICC line or central port; and
- TPN or nutrition via G-tube.

Home Health Care Services

Home health services are services that are generally provided in the recipient's home. Tennessee Public Chapter 471 authorizes home health nurses and aides to accompany a recipient outside the home during the course of prior approved home health services if all of the following criteria are met:

1. The home health nurse or aide must not transport the service recipient.
2. The home health agency will have discretion as to whether or not to accompany a recipient outside the home.
3. Additional visits or hours of care will not be approved for the purpose of accompanying a recipient outside the home.
4. No additional reimbursement will be paid to the home health agency in association with the decision of the agency to accompany a patient outside the home.

This Act specifies that its provisions are not intended to create an entitlement to services and that a home health agency will not be subject to legal action as a result of exercising its discretion pursuant to this amendment.

Rev 09/18
Home Health Care services require prior authorization from BlueCare Tennessee Utilization Management. The following services are covered when ordered by a treating Practitioner and provided by a licensed Home Health agency pursuant to a plan of care at a Member’s place of residence:

- Part-time or intermittent nursing services;
- Home health aide services;
- Physical or occupational therapy;
- Speech pathology;
- Audiology services; and
- Medical social services.

Home Health Providers may only provide services to the recipient that have been ordered by the treating Physician and are pursuant to a plan of care and may not provide other services such as general child care services, cleaning services, preparation of meals, or services to other household members. To the extent that home services are provided to a person under 18 years of age, a responsible adult (other than the home health Provider) must be present at all times in the home during provision of home health services unless all of the following criteria are met:

1. The child is non-ambulatory; and
2. The child has no or extremely limited ability to interact with caregivers; and
3. The child shall not reasonably be expected to have needs that fall outside the scope of Medically Necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health Provider would be present in the home without the presence of another responsible adult; and
4. No other children shall be present in the home during the time the home health Provider would be present in the home without the presence of another responsible adult.

If a responsible adult is not present, the care must still be provided and BlueCross BlueShield of Tennessee should be notified immediately if this occurs.

The following home health coverage limits apply for Members 21 years and older:

**Limits for most TennCare Adults:**

<table>
<thead>
<tr>
<th>Home Health Aide Care</th>
<th>Home Health Nurse Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Extended Visits (S-Code: S9122)</strong> Up to 35 hours per week</td>
<td>- <strong>Extended Visits (S-Codes: S9123/S9124)</strong> Up to 27 hours per week</td>
</tr>
<tr>
<td>- No more than 8 hours/day</td>
<td>- No more than 8 hours/day</td>
</tr>
<tr>
<td>- No more than 2 visits/day</td>
<td>- No more than 1 visit/day</td>
</tr>
<tr>
<td>- HH aide and nurse combined cannot exceed 35 hours per week</td>
<td>- HH nurse and aide care combined cannot exceed 35 hours per week</td>
</tr>
<tr>
<td>- <strong>For example, 35 hours =</strong></td>
<td>- <strong>For example 27 hours =</strong></td>
</tr>
<tr>
<td>- 7 hours, 5 days/week</td>
<td>- 5 hours, 5 days/week</td>
</tr>
<tr>
<td>- 5 hours, 7 days/week</td>
<td>- 3.5 hours, 7 days/week</td>
</tr>
<tr>
<td>- <strong>Intermittent Visits (G-Code: G0156)</strong> Up to 7 hours/28 units per week</td>
<td>- <strong>Intermittent Visits (G-Codes: G0299/G0300)</strong> Up to 7 hours/28 units per week</td>
</tr>
<tr>
<td>- Up to 4 units maximum (15 minute increments) per day</td>
<td>- Up to 4 units maximum (15 minute increments) per day</td>
</tr>
<tr>
<td>- 4 units (15 minute increments) may be provided in 2 visits/day</td>
<td>- Limit of 1 visit/day</td>
</tr>
<tr>
<td>- <strong>For example, 4 units per day =</strong></td>
<td>- <strong>For example, 4 units per day =</strong></td>
</tr>
<tr>
<td>- 2 units (30 minutes) in AM on Monday</td>
<td>- No more than 60 minutes on Monday, Wednesday, and Friday for 3 visits per week</td>
</tr>
<tr>
<td>- 2 units (30 minutes) in PM on Monday</td>
<td></td>
</tr>
<tr>
<td>- 4 units (60 minutes) in one visit Tuesday</td>
<td></td>
</tr>
</tbody>
</table>
Limits for TennCare Adults who need one (1) or more of the skilled or rehabilitative services for Nursing Facility Care noted within TennCare Rule 1200-13-01-.10:

<table>
<thead>
<tr>
<th>Home Health Aide Care</th>
<th>Home Health Nurse Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Up to 40 hours per week</td>
<td>➢ Up to 30 hours per week</td>
</tr>
<tr>
<td>- No more than 8 hours/day</td>
<td>- No more than 8 hours/day</td>
</tr>
<tr>
<td>- No more than 2 visits/day</td>
<td>- No more than 1 visit/day</td>
</tr>
<tr>
<td>- HH aide and nurse combined cannot exceed 40 hours per week</td>
<td>- HH nurse and aide care combined cannot exceed 40 hours per week</td>
</tr>
<tr>
<td>➢ For example, 40 hours =</td>
<td>➢ For example 30 hours =</td>
</tr>
<tr>
<td>- 8 hours, 5 days/week</td>
<td>- 6 hours, 5 days/week</td>
</tr>
<tr>
<td>- 5.5 hours, 7 days/week</td>
<td>- 4 hours, 7 days/week</td>
</tr>
</tbody>
</table>

Note: Requests for home health nursing and aide services greater than eight (8) hours, and all Private Duty Nursing services for BlueCare and TennCareSelect Members should be submitted via e-Health Services on the company website, [http://bluecare.bcbst.com](http://bluecare.bcbst.com) or faxed to 1-865-588-4663, 1-423-535-5254, or 1-800-292-5311. Submit using the Private Duty, Skilled Nurse, Home Health Aide request form located on BlueCare Tennessee website at [https://bluecare.bcbst.com/providers/forms.html](https://bluecare.bcbst.com/providers/forms.html).

All Providers requesting and providing services and seeking claims payments for BlueCare/TennCareSelect/CoverKids Members are required to register for a Tennessee Medicaid ID number via the Divisions of TennCare’s Provider Registration website, [https://pdms.tenncare.tn.gov/Account/Login.aspx?ReturnUrl=%2f](https://pdms.tenncare.tn.gov/Account/Login.aspx?ReturnUrl=%2f). Claims submitted by and/or ordered by unregistered Providers will be ineligible for payment.

Prior authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing services must be obtained in order to establish the Medical Necessity of all requested home health nurse, home health aide, and private duty nursing services.

(a) The following information must be provided when seeking prior authorization for all home health nurse, home health aide, and private duty nursing services:

1. Name of Physician prescribing the service(s)
2. Specific information regarding the Member’s medical condition and any associated disability that creates the need for the requested service(s)
3. 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 member 7 a.m., 12 p.m., and 5 p.m. daily; bathe member once per day; administer medications three (3) times per day; catheterize member as needed from 8 a.m. to 5 p.m. Monday through Friday; change dressing on wound three (3) times per week. Such information should also include the total period of time that the services are anticipated to be Medically Necessary by the treating Physician (e.g. total number of weeks or months).

(b) Home health nurses or aides may accompany a recipient outside the home during the course of delivery of prior approved home health nurse or home health aide services if all of the following criteria are met:

1. The home health nurse or home health aide shall not transport the recipient;
2. The home health agency shall have discretion as to whether or not to accompany a recipient outside the home. The circumstance under which a home health agency may exercise such discretion shall include without limitation when the home health agency has concern regarding any of the following:
   i. The scheduling or safety of the transportation;
   ii. The health or safety of their employee or the recipient;
   iii. The ability to safely and effectively deliver services in the alternative setting;
   iv. The additional expense that would be required to accompany a patient outside the home;
v. Additional visits or hours of care will not be approved for coverage for the purpose of accompanying a recipient outside the home. Services will be limited to services to which the recipient would be entitled if the services were provided exclusively at the recipient’s place of residence;
vi. No additional reimbursement shall be paid to the home health agency in association with the decision of a home health agency to accompany a patient outside the home;
vii. Nothing in this subdivision is intended to create an entitlement to services outside the home.

3. A home health agency shall not be subject to any claims or cause of action as result of exercising its direction under this subdivision.

(c) Private duty nursing services are limited to services provided in the recipient’s own home (except as defined by federal regulations), with the following two exceptions:

1. A recipient age twenty-one (21) or older who requires eight (8) or more hours of skilled nursing care in a 24-hour period and is authorized to receive private duty nursing services in the home setting may make use of the approved hours outside of that setting in order for the nurse to accompany the recipient to:
   i. Outpatient health care services (including services delivered through a TennCare home and community based services waiver program);
   ii. Public or private secondary school or credit classes at an accredited vocational or technical school or institute of higher education;
   iii. Work at their place of employment.

2. A recipient under the age of twenty-one (21) who requires eight (8) or more hours of continuous skilled nursing care in a 24-hour period and is authorized to receive these services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him or her outside of that setting. Normal life activity for a child under the age of 21 means routine work (including work in supported or sheltered work settings); licensed childcare; school or school-related activities; religious services or related activities; and outpatient health care services (including services delivered through a TennCare home and community based services waiver program). Normal life activities do not include non-routine or extended home absences. A private duty nurse may accompany a recipient in the circumstances outlined immediately above, but may not drive.

Home health agencies are required to notify BlueCare Tennessee when home health/private duty shifts are not covered. A non-covered shift is defined as any scheduled home health/private duty visit or service that does not occur, including partially covered and future open shifts. It is the responsibility of the home health agency to provide coverage for all shifts/visits and exhaust all coverage possibilities prior to calling BlueCare Tennessee. If the home health agency is unable to cover a shift/service, Effective October 1, 2009, BlueCare Tennessee notification is initiated by calling the new Home Health Compliance hotline, 1-800-215-3851, every day there is a non-covered shift. Effective with implementation of the new compliance line, BlueCare Tennessee will no longer accept faxed notification. Accurate and timely reporting will result in appropriate actions to ensure that the Member’s needs are met and that this information is reported properly.

Note: Home health agencies should only submit claims for services actually rendered. Any liquidated damages, penalties, or fines assessed against BlueCare Tennessee by the Division of TennCare as relates to non-covered visits by the home health agency shall be deferred to the home health agency for payment.

Prescription Drugs

Prescription drug benefits are provided through the State of Tennessee, Division of TennCare’s Pharmacy Benefit Manager (PBM) Magellan Medicaid Administration, Inc. Providers are responsible for following the preferred drug list (PDL). Additionally, Providers shall coordinate pharmacy prior authorization requests with the TennCare PBM.
Effective January 1, 2006, if prior approval is not requested by the Physician for a medication requiring prior approval, the pharmacy can give a three-day supply if the pharmacist deems it an emergency\(^1\). See Billing Procedures, Section V.O. Pharmacy Benefits Manager (PBM) Program.

\(^1\)An emergency situation, for these circumstances, is a situation that in the judgment of the dispensing pharmacist involves an immediate threat of severe adverse consequences to the Member, or the continuation of immediate and severe adverse consequences to the Member if an outpatient medication is not dispensed when the prescription is submitted. For more information, visit the Division of TennCare website, https://www.tn.gov/tenncare/providers/pharmacy.html.

Effective 3/2/2018, Primary Care Providers can access Member pharmacy-related claims data via Availity, BlueCare Tennessee’s secure area on the company website, http://bluecare.bcbst.com/.

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**Durable Medical Equipment (DME)**

Effective 11/1/2012, BlueCare Tennessee will administer and manage all Durable Medical Equipment, Medical Supply services, and Orthotics and Prosthetics by BlueCare and TennCare Select Members. BlueCare Tennessee will manage authorizations and arrangements for DME and medical supply services. (For contact information, see Section VIII. Utilization Management Program in this Manual.)

Benefits are provided for the rental or, if approved, the purchase of durable medical equipment when Medically Necessary and prescribed in writing by a Practitioner. Prior authorization is required for all DME and O&P purchased or rented from a DME supplier unless listed on the no prior authorization required list found on the BlueCare Tennessee website, https://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf.

“Durable Medical Equipment” means equipment that is:

- Only used to serve the medical purpose for which it is prescribed;
- Not useful to the Member or other person in the absence of illness or injury;
- Able to withstand repeated use; and
- Appropriate for use within the home.

Some equipment may not be an eligible expense even if a Practitioner or other Provider prescribes it. (Refer to Benefit Exclusions at the end of this section.)

When equipment is rented and the rental extends beyond the original prescription, a Practitioner must obtain a certificate of Medical Necessity that the equipment is Medically Necessary for continued treatment. If a certificate of Medical Necessity is not submitted, benefits will not continue beyond the original approval end date. (Refer to Utilization Management section in this Manual for authorization requirements.)

**Phenylketonuria (PKU) Treatment**

Licensed professional medical services under the supervision of a Physician and those special dietary formulas that are Medically Necessary for the therapeutic treatment of phenylketonuria (PKU) are covered.

**Prosthetic Appliances**

Benefits are provided for prosthetic appliances (except cosmetic prosthetic devices) needed to replace all or part of an absent or malfunctioning body part, including surrounding tissue; to also include fitting, adjustment, repair or replacement due to normal wear, as determined by BlueCare Tennessee, or the Member’s physical development. All prosthetic appliances/devices serviced or supplied by a prosthetic Provider require prior authorization unless listed on the no prior authorization required list found on the BlueCare Tennessee website, https://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf. BlueCare Tennessee will manage all prosthetic authorization requests.
Orthotic Devices

All orthotic devices serviced or supplied by an orthotic Provider require prior authorization unless listed on the no prior authorization required list found on the BlueCare Tennessee website, https://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf. BlueCare Tennessee will manage all orthotic authorization requests.

Therapy and Rehabilitation Services

Benefits are provided for the following forms of therapy:

- Radiation therapy
- Chemotherapy
- Dialysis treatment
- Physical therapy**
- Speech therapy*
- Respiratory therapy
- Occupational therapy**
- Medical rehabilitation services
- Allergy therapy

*Covered as Medically Necessary to restore speech.
**Covered as Medically Necessary to restore, improve or stabilize impaired functions.

Note: Inpatient rehabilitation hospital facility services are not covered for adults unless determined to be cost-effective. All inpatient admissions require prior authorization. (Refer to Utilization Management section in this Manual for authorization requirements.)

Hospice Services

Benefits are provided for hospice care when the Member’s Practitioner establishes a plan of treatment and an approved Provider of hospice care provides the services. Hospice services must be provided by an organization certified by and in accordance to the Medicare Hospice requirements. Hospice services require notification. Medicare dual eligible Members do not require notification for Hospice.

If a service that a Member needs can be provided through the hospice benefit, it must be provided through the hospice benefit and not through CHOICES. CHOICES services may supplement but not supplant hospice benefits available to the Member through either Medicare or TennCare.

Under the Patient Protection and Affordable Care Act (PPACA) hospice amendment, children who elect to receive hospice care may also elect to continue to receive curative treatment for their terminal illness. Section 2302 of the Act amends Section 1905 (o) (1) of Title XIX of the Social Security Act and states, “voluntary election to have payment made for hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payment for, services that are related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made”.

The Provision applies only to children, including children who elected hospice care prior to the date of enactment, i.e., if the child entered hospice care in February 2010, but now wishes to receive concurrent treatment, the previous election to receive hospice services cannot be construed as a waiver of the right to receive curative services.

Note: The rules continue to prohibit concurrent treatment for adults in Medicaid.

Vision Services

All BlueCare Tennessee Members are eligible for vision benefits when services are for the treatment of an illness or injury to the eye(s). Preventive, diagnostic and treatment services (including eyeglasses) are available for each Member under the age of 21 years.

Evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state) is covered for Members age 21 and older. The first pair of cataract glasses and or contact lens/lenses following cataract surgery is covered for adults.
Dental Services

The Division of TennCare and DentaQuest entered into an arrangement effective 10/1/2013, where DentaQuest will administer and manage dental services for all TennCare Members under the age of 21 years for all Managed Care Organizations.

If you have any questions or need additional information, please call DentaQuest Customer Service at 1-800-294-9650.

TennCare for Prisoners Program

Effective April, 1, 2015, State law (HB 1904 – SB 2023) authorizes inmates who are otherwise eligible for TennCare to be eligible for temporary reinstatement of medical assistance for services received outside of a jail or correctional facility in a hospital or other health care facility for more than 24 hours. Once the Division of TennCare has been notified that a TennCare Member has been incarcerated in a public correctional institution, the Division of TennCare will suspend the Member's coverage and assign the Member to TennCare Select with limited benefits.

Medical and behavioral health assistance received in a hospital or other health care facility for more than 24 hours are covered if Medically Necessary. All services (including professional) associated with the approved episode of care should be covered. All other services will be denied as non-covered.

All authorization requirements still apply. Facilities may not have knowledge of the Member’s enrollment in TennCare Select under this program prior to treatment. To accommodate the facility’s needs, TennCare Select will allow for retro-authorization requests for these Members. A specific denial explanation code of WX0 has been created for services that deny due to no prior authorization for this population. This code will indicate that the facility needs to request a retro-active authorization in order for the claim to be considered for adjustment if authorized. If the Member’s eligibility is made retroactive, the Provider will have 120 days from the remit date of the denial on the claim to request a retro-active authorization. If the Member’s eligibility is NOT retro-active, the Provider will have 24 hours or next business day to request an authorization. Any UM requests made outside of this time frame may be denied non-compliant.

Covered services include:
- Medical and behavioral health services performed in a hospital or other health care facility for more than 24 hours.
- All Medically Necessary services (including professional) associated with the above mentioned episode of care
  - Supplies and equipment (e.g., diabetic supplies, casts, etc.) that are provided during the episode of care

Note: If supplies and/or equipment are provided thereafter, the jail/prison authorities have this responsibility. If a Provider files a claim for services not covered under the TennCare for Prisoners program the claim will be denied XNN.

Babies Born to Incarcerated Mothers

Claims for babies born to incarcerated mothers should not be filed under the mother’s identification number. Claims must be filed using the baby’s ID number. Children born to an incarcerated mother will be required to have their own ID number using existing business processes, and the newborn will be added to TennCare with an effective date of the child’s date of birth. This will help ensure the infant has full TennCare benefits from birth. Global OB services are not covered under the mother’s limited TennCare benefits. Only the inpatient stay associated with the delivery will be covered if the admission is greater than 24 hours. The delivery does not require an authorization, only clinical notification.

For all questions related to benefits, claims payment and authorization requirements, please call the TennCare Select Provider Service line, 1-800-276-1978.

The Division of TennCare determines eligibility. Eligibility may be verified through the Division of TennCare’s Online Eligibility Services website at https://www.tn.gov/tenncare/providers/verify-eligibility.html. Normal requirements associated with claims billing and authorization of services apply.
B. Benefit Exclusions

The Exclusions section of the TennCare Rules located at http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm is maintained and updated by the Division of TennCare. The services, products and supplies listed in the exclusion rules apply to all Members unless the rules require a Medical Necessity review for Members under the age of 21 years.

 Providers should routinely view the most current Exclusions list, available on the Division of TennCare’s website at the above website address.
V. Billing and Reimbursement

Note: All of the following billing and reimbursement guidelines apply for CoverKids unless specifically stated otherwise.

In February 2013, the State of Tennessee launched a state-wide initiative, Tennessee Health Care Innovation Initiative (THCII), to begin transitioning its TennCare health care payment system to an episode-based payment system that rewards patient-centered high quality care, promotes the use of clinical pathways and evidence-based guidelines, encourages coordination, and reduces ineffective and/or inappropriate care.

The THCII is led by the state Division of TennCare but includes a broad coalition of stakeholders with close involvement from many leading health care Providers. Under the initiative, the goal is to shift the majority of health care spending into outcome-based payment and service delivery models for all lines of business.

As of 1/1/2015, BlueCare Tennessee began gathering and calculating performance data for episodes based on the State’s episode of care model. Gain and risk-share incentive payments began in 2016.

By 2019, approximately 75 episodes of care will be rolled out in Waves. Each Wave will include a specific number of episodes of care as assigned by the State of Tennessee. To see each Wave and the episodes of care within each Wave, please go to the State of Tennessee website at https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html.

To help you learn more about the Tennessee Health Care Innovation Initiative, we developed a number of Frequently Asked Questions and a Provider Guide that can be accessed on the Provider page on the company websites at https://bluecare.bcbst.com/providers/quality-care/thcii.html and http://www.bcbst.com/providers/episode-of-care.page.

Episodes of care reports are available on Availity®, BlueCare Tennessee’s secure web portal. Just log on and scroll to the link “Tennessee Health Care Innovation Initiative”. Select the reporting period and line of business to review. Providers can also find more information on the State of Tennessee’s website at http://www.tn.gov/tenncare/section/health-care-innovation.

If you are not registered on Availity, go to http://www.Availity.com and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

A. How to File a BlueCare/TennCareSelect Claim

Effective July 1, 2013, all network Providers are required to submit claims electronically rather than by paper format. Submitting claims electronically helps ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes. If you need assistance submitting claims electronically, please contact eBusiness Provider Solutions at (423) 535-5717 Option 2, Monday through Thursday 8 a.m. to 5:15 p.m. (ET) or Friday 9 a.m. to 5:15 p.m. (ET).

In an effort to better protect patient data and adhere to ANSI claim filing guidelines, BlueCare Tennessee will begin rejecting claims submitted with the Member ID number as a Social Security Number (SSN). The Member ID is located within loop 2010BA in the NM1 segment.

This change will affect ANSI 837 Professional, Institutional, and Dental transactions submitted on or after Oct. 1, 2014. When filing claims to BlueCare Tennessee, be sure to use the identification number found on the Member’s ID card. For questions about this change, please contact eBusiness Technical Support at 1-423-535-5717, Option 2.

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Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

1. Filing Electronic Claims (Required Method)
BlueCross BlueShield of Tennessee/BlueCare Tennessee implemented an electronic claims processing system in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BlueCross BlueShield of Tennessee business edits have been modified to recognize the new ANSI formats. These edits apply to both electronic and scannable paper claims.

Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:
Claims submitted electronically must include the Provider’s appropriate National Provider Identifier (NPI), and the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com Additional companion documents needed for BlueCare Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/ecommm/technical-information.shtml.

Note: BlueCross BlueShield of Tennessee follows the Center for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

Electronic Enrollment and Support
Enrollment of new Providers, changes to existing Provider or billing information (address, tax ID, Provider number, NPI, name), or any changes of software vendor should be communicated to eBusiness Provider Solutions via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded from the company website, www.bcbst.com or obtained upon request. Failure to submit a Provider Electronic Profile form when changes to electronic submission information occur can result in delays in claims payment or disruption of electronic claims submissions. Mail or Fax Provider Electronic Profile forms to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Services
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN 37402-0007
Fax: (423) 535-7523

For technical support or enrollment information, call, fax, or e-mail:

Technical Support Enrollments
call: (423) 535-5717 call: 1-800-924-7141
fax: (423) 535-3334 fax: (423) 535-3334
e-mail: eBusiness_Service@bcbst.com e-mail: eBusiness_SysConfig@bcbst.com

Electronic Data Interchange (EDI)
HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCare Tennessee uses the ANSI 837 version, 5010 format. Effective October 18, 2011, we began accepting the ANSI 837 version, 5010 format.

American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

Secure File Gateway (SFG)
The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the
ability to transmit files to BlueCross BlueShield of Tennessee using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTTPS Website, <a href="https://mftweb.bcbst.com/myfilegateway">https://mftweb.bcbst.com/myfilegateway</a></td>
<td>The BlueCross BlueShield of Tennessee secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>SFTP (server mftsftp.bcbst.com)</td>
<td>The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>FTP/SSL (server mftsftp.bcbst.com)</td>
<td>The BlueCross BlueShield of Tennessee FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
</tbody>
</table>

**ANSI 837 (Version 5010)**

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*.

*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer.


2. **Filing Paper Claims**

   **Note:** Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

   When completing a paper claim, please reference the most recent editions of the manuals or refer to the Data Elements required for submitting CMS-1500 claims included later in this section.

   CMS-1450 Hospital Manual  ICD Code Manuals

   Also refer to the Data Elements required for submitting CMS-1500 claims included later in this section. In order to assure precise control and timely and accurate payment of claims and to reduce the potential of fraud, BlueCross BlueShield of Tennessee will not accept claims faxed, photocopied or altered; claims which do not meet exception criteria listed below will be returned to the Provider:

   - **Faxed and Photocopied Claims:** All faxed and photocopied claims must be approved by BlueCross BlueShield of Tennessee management or faxed at the request of BlueCross BlueShield of Tennessee.
   - **Altered Claims**: All altered claims are returned to the Provider with an attachment stating BlueCross BlueShield of Tennessee does not accept claims that have been altered.

   *Altered claims are claims with whiteout or, which BlueCross BlueShield of Tennessee Operations determines are suspicious.*
B. Tips for Completing CMS-1500/CMS-1450 Claim Forms

**Note**: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Listed below are some tips that will help ensure claims are processed rapidly and accurately.

All services for the same patient, same date of service, same place of service, and same Provider must be billed on a single claim submission.

**General tips whether submitting OCR or paper:**

- Use red standard claim form;
- Type all letters in uppercase (capital letters);
- Align all print in appropriate blocks;
- Use a black typewriter ribbon (if typed) or block letters (if handwritten) to reflect a clear impression;
- Enter insured’s ID number including the three-letter alpha prefix, exactly as shown on ID card;
- Review each claim to ensure all required fields have been provided;
- Send only original claims and supporting documentation;
- Securely staple any attachments or receipts;
- Do not use correction tape or whiteout when submitting paper claims; and
- Date spans can be submitted but each line must be specific and match the exact amount of units billed. See Chapter 25 of the CMS Manual that states how date spans should be used.

**Billing Requirements for Faxed PWK Attachments (PWK-Paperwork)**

BlueCare Tennessee follows BCBST billing requirements for Faxed PWK Paperwork. When paper documentation is necessary to support an electronically submitted claim, you can utilize the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to BCBST separately from the electronic claim. The actual supporting documentation would be faxed accompanied with a PWK Fax Cover Sheet. BCBST will match the documentation to your electronic claim using the information supplied from the PWK06 segment and PWK Fax Cover Sheet and utilize that documentation during claims processing and payment. To ensure BCBST matches the documents to an electronic claim for processing; the documentation and fax sheet should be submitted no later than the day of claims submission.

BCBST will only match on the first iteration of PWK06 (ACN) from the ANSI 837 data.

Ensure your first iteration at claim or line level matches the PWK06 (ACN)

<table>
<thead>
<tr>
<th>ANSI 837 Loop</th>
<th>Field Description</th>
<th>837P/I Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>Attachment Report Type Code&lt;br&gt;Use the values indicated in the IG to identify the type of attachment.</td>
<td>PWK01</td>
</tr>
<tr>
<td>2300</td>
<td>Attachment Transmission Code&lt;br&gt;Use the values indicated in the IG to identify how the attachment will be sent. BCBST accepts supporting documentation by fax only, the value of FX (By Fax) in this data element is the only value accepted.</td>
<td>PWK02</td>
</tr>
<tr>
<td>2300</td>
<td>Identification Code Qualifier&lt;br&gt;Use code value of AC (Attachment Control Number). This data element is required if PWK02 = FX.</td>
<td>PWK05</td>
</tr>
<tr>
<td>2300</td>
<td>PWK06 Attachment Control Number&lt;br&gt;This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the “Attachment Fax Sheet”.</td>
<td>PWK06</td>
</tr>
</tbody>
</table>
Example: PWK*M1*FX***AC*BCBS1234~

- Only include your attachment control number (ACN) reported in the PWK06 segment of the claim.
- Complete ONE (1) Fax Cover Sheet for each electronic claim for which documentation is being submitted.

**Note:** The PWK Fax Cover Sheet can be found on the company website at http://www.bcbst.com/docs/providers/PWK-Coversheet.pdf. Complete the form and fax with documentation to (423) 591-9481.

**CMS-1500 Specific**

- All date information should be shown in the following format (except Block 24A –Date of Service):
  
  MMDDCCYY
  
  MM=month (01-12)
  
  DD=day (01-31)
  
  CCYY-year (0000-9999)

  Example: January 1, 2004 = 01012004

  Do Not exclude leading zeros.

  Block 24A (Date of Service) should be a continuous 6-digit number (Correct: January 1, 2004 = 010104).

  - Enter the Individual Provider's Name, billing address in Block 33;(Keep the Provider's signature within signature Block 31);
  
  - Enter the NPI number of the billing Provider in Block 33a;
  
  - Enter the two-digit qualifier identifying the non-NPI number followed by the ID number in Block 33b. Do not enter a space, hyphen, or other separator between the qualifier and number.
  
  - Enter the name and address of the facility where the services were rendered in Block 32. When the name and the address of the facility where services were rendered is the same as the name and address shown in Block 33, enter the word “SAME”;
  
  - Enter the NPI number of the service facility location in Block 32a;
  
  - Enter the two-digit qualifier identifying the non-NPI number followed by the ID number in Block 32b. Do not enter a space, hyphen, or other separator between the qualifier and number;
  
  - List non-BlueCare/TennCare Select PCP Physician extender name in Block 31 and supervising BlueCare/TennCare Select Physician in Block 33.
  
  - Multi-page Claims:
    
    - List diagnosis code(s) for all conditions related to the patient’s illness on each page.
    
    - Place the total amount **only on the last page of the claim**. The total on the last page should reflect the sum of the line items for all pages.
    
    - Use the words “Continued on next page” or “Page X of X” in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
    
    - Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
    
    - Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.
    
    - Donor/Recipient information when filing transplant claims:
      
      - Block 2 should contain the patient name that received the service “In this case it will be the Donor”.
      
      - Block 19 should contain the patient name that received the service “In this case it will be the Donor”.
      
    - Block 19 should be marked “Donor” and contain the “Recipient’s name”.

  **CMS-1450 Specific**

- All date information should be shown in the following format (except Form Locator 10 –Birth Date):
  
  MMDDYY
  
  MM=month (01-12)
DD=day (01-31)
YY=year (00-99)
Example: January 1, 2004 = 010404

- Do not exclude leading zeros in the date fields;
- Multi-page Claims:
  - All diagnosis code(s) listed on first page must be listed on each page.
  - Place the total amount and 0001 Total Revenue Code only on the last page of the claim. The 0001 Total Revenue Code line on the last page of the claim should reflect the sum of the line items for all pages.
  - Use the words “Continued on next page” or “Page X of X” on line 23 on each page (except on the last page, which reflects the total charge on the 0001 Total Revenue Code line).
  - Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.
- Donor/Recipient information when filing transplant claims:
  - Block 8 should contain the patient information of the person that received the service. “In this case it will be the Donor”.
  - Block 58 should contain the Subscriber, the Recipient name, “if different from the Subscriber” and the charges making the recipients plan BlueCross Secondary.
  - Block 59 on the subscriber/recipient lines should contain the Patient Relationship code “39”. (39="Organ Donor").

BlueCross/BlueCare Tennessee updates OCR scanning processes for CMS-1500 and CMS-1450 paper claims. Following the Current Official UB-04 Data Specifications Manual guidelines, this update will not require any changes related to the CMS-1500, however the following changes will be required when submitting CMS-1450 paper claims:

- **Form Locator 12 - Admit Date:** Admit date should only be populated for inpatient, home health, and hospice claims. A rejection will occur for any other claim type.

- **Form Locator 13 - Admit Hour:** Admit hour should only be populated for inpatient claims, excluding type of bill 021x. A rejection will occur for any other claim type.

- **Form Locator 15 - Admission Source:** Admission source should be populated for ALL institutional claims except those with a TOB 014X. Any UB-04 (or its successor) claim forms submitted without an Admission Source will be rejected and returned for correction.

- **Form Locator 69 - Admitting Diagnosis Code:** Admitting diagnosis code is only required for inpatient claims. A rejection will occur for any other claim type.

- **Form Locator 74 - Principal Procedure Code:** Principal procedure code should only be submitted for inpatient claims. A rejection will occur for any other claim type.

- **Form Locator 74a-e - Other Procedure Code:** Other procedure codes should only be submitted for inpatient claims. A rejection will occur for any other claim type.

Reminder: To ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted on or after 10/1/2012, with a discharge status 20, 40, 41, or 42 must also include an Occurrence Code 55, and date of death.

NUBC is responsible for the design and printing of the UB-04. Additional information for the UB-04 is available to subscribers. If you are interested in additional information please visit the NUBC at www.nubc.org.

The National Uniform Claim Committee (NUCC) maintains the 1500 form. Visit the NUCC “1500 Health Insurance Claim Form Reference Instruction Manual” at http://www.nucc.org for additional information. From the top of the website, select “1500 Claim Form,” then “1500 Instructions.”
Returned Claims and Processed Claims Needing Correction

Incomplete Claims
Incomplete claims are claims that do not conform to the billing guidelines. These claims have NOT been processed and will be returned to the Provider. Incomplete electronic claims are reflected on the Provider’s 277 Claim Acknowledgment Report. Since incomplete returned claims have not been processed (providers have not received a Remittance Advice for these claims), the claim will not be denied “duplicate” when resubmitted. Images of all rejected and accepted claims will be maintained in BlueCare Tennessee’s archives for future reference.

Corrected Bills
Effective January 1, 2013, Corrected bills must be submitted within 120 days of the last BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

Claims that have been processed (providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a “Corrected Bill”. A true corrected bill includes additional/changed dates of service, procedure or diagnostic codes, units, member name, ID and/or charges that were not filed on the original claim.

Note: Claims returned or rejected should not be submitted as corrected claims. Only claims that have completed adjudication should be submitted as corrected bills. When sending a Corrected/Replacement Claim you must re-send the claim in its entirety including the corrections.

Corrected Electronic Claims (Required Method)
If a claim is denied on a remittance advice, it requires correction and resubmission electronically. Corrected Bills for Institutional and Professional claims can be filed electronically in the ANSI-837, version 5010 format. The following guidelines are based on National Implementation Guides found at http://www.wpc-edi.com and BlueCare Tennessee /BCBST Companion Documents found at: http://www.bcbst.com/providers/ecomm/technical-information.shtml

ANSI-837P – (Professional) and ANSI-837I – (Institutional)
In most instances, claims correction should be submitted in an electronic format.

1. In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:
   - “7” – REPLACEMENT (Replacement of Prior Claim)
   - “8” – VOID (Void/Cancel of Prior Claim)

2. In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the electronic remittance advice.
   - REF01 must contain ‘F8’
   - REF02 must contain the original BCBST claim number
   Example: REF*F8*1234567890~

3. In the 2300 Loop, the NTE segment (free-form ‘Claim Note’), must include the explanation for the Corrected/Replacement Claim.
   - NTE01 must contain ‘ADD’
   - NTE02 must contain the free-form note indicating the reason for the corrected/replacement
   Example: NTE*ADD*CORRECTED PROCEDURE CODE ON LINE 3

For Technical Support assistance, contact eBusiness Technical Support at 423-535-5717 (Option 2) or via e-mail at Ecomm_TechSupport@bcbst.com. Technical support is available Monday through Thursday, 8 a.m. to 5:15 p.m. (ET), and Friday, 9 a.m. to 5:15 p.m. (ET).
Corrected Paper Claims - Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Submit a new claim form with the correct data as follows:

- **CMS-1500 Claim Form**
  - Submit a Frequency Code “7” (Replacement of prior claim) or “8” (Void/Cancel of prior claim) in the “Resubmission Code” field of Block 22.
  - The claim number originally used by BlueCare Tennessee to process the claim should be included in the “Original Ref. No.” field of Block 22.
  - Failure to include the appropriate “Resubmission Code” and “Original Ref. No.” in Block 22 may result in a claim rejection or denial.

- **CMS-1450 Claim Form**
  - Submit a Frequency Code “7” (Replacement of prior claim) or “8” (Void/Cancel of prior claim) as the fourth digit in the “Type of Bill” field (FL 4).
  - The claim number originally used by BlueCare Tennessee to process the claim should be included in the “Document Control Number” (DCN) field (FL 64).
  - Failure to include the appropriate “Frequency Code” in FL 4 and “Document Control Number (DCN)” in FL 64 may result in a claim rejection or denial.

The above listed guidelines align with NUCC & NUBC billing requirements as well as (ASC X12) Health Care Claim: Professional (837P) & Institutional (837I) Version 5010 requirements.

**National Drug Code (NDC) Claim Filing (Previously Provider-Administered Drug Claims)**

Beginning January 1, 2007, the Deficit Reduction Act (DRA) of 2005 required states to collect rebates on Provider-administered drugs. Effective with dates of service June 1, 2007, and forward, providers must include the National Drug Code (NDC) of the drug(s) administered, along with the correct quantity and unit, for all provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format with some exceptions indicated below. Home Infusion Therapy Providers should continue submitting claims using the same codes in place today. All other Providers should submit claims with the NDC information for "J" codes only.

**Exceptions to NDC Requirement for Provider-Administered Medical and Facility Drug Claims:**

- Vaccines
- Inpatient administered drugs

**Note:** Effective with date of service 4/01/08 and after, NDC requirements must also be fulfilled by facilities filing Outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format with the same exceptions listed above. NDC information is not required on Inpatient UB claims. When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/CPT® code. Any missing element may result in the claim being returned unprocessed.

**National Drug Code (NDC) Electronic Billing Requirements**

When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/CPT® code. Any missing element will result in the claim being returned unprocessed.

In Loop 2410:

- **LIN02** must equal “N4” and **LIN03** must contain an 11 digit NDC number.
  
  Example: LIN**N4*01234567891~

- **CTP04** must contain a numeric value, which quantifies the number of units, grams or mililters administered. Decimal points are allowed in the event they are needed.

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- CTP05-1 must contain one of the NDC Quantity Qualifiers (F2- International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-Unit)

Example: CTP***2'UN~

Not Otherwise Classified (NOC) Drug Code Billing
When billing NOC J-codes in the ANSI 837 format you are required to provide a description of the drug in the 2400 Loop, SV101-7 (Professional), SV202-7 (Institutional).

Example: SV1/2*HC:J3490::FO FOLIC ACID 5MG*5.62*UN*1***3~

In order for BlueCare Tennessee to correctly reimburse NOC J-codes, providers must indicate the following in the electronic narrative: the name of the drug, total dosage (plus strength of dosage, if appropriate) and method of administration.

<table>
<thead>
<tr>
<th>ANSI 837 Loop</th>
<th>Field Description</th>
<th>837P Segment</th>
<th>837I Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2400</td>
<td>Drug Name description information</td>
<td>SV101-7</td>
<td>SV202-7</td>
</tr>
<tr>
<td>2400</td>
<td>Drug Ingredient Billed Amount</td>
<td>SV102</td>
<td>SV203</td>
</tr>
<tr>
<td>2400</td>
<td>HCPCS Unit of Measure</td>
<td>SV103</td>
<td>SV204</td>
</tr>
<tr>
<td>2400</td>
<td>HCPCS Quantity</td>
<td>SV104</td>
<td>SV205</td>
</tr>
<tr>
<td>2410</td>
<td>NDC Qualifier of N4</td>
<td>LIN02</td>
<td>LIN02</td>
</tr>
<tr>
<td>2410</td>
<td>NDC code (11 digits)</td>
<td>LIN03</td>
<td>LIN03</td>
</tr>
<tr>
<td>2410</td>
<td>NDC Quantity</td>
<td>CTP04</td>
<td>CTP04</td>
</tr>
<tr>
<td>2410</td>
<td>NDC Unit of Measure (F2, GR, ME, ML, UN)</td>
<td>CTP05-1</td>
<td>CTP05-1</td>
</tr>
</tbody>
</table>

Paper Claim Submission - Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

In the shaded portion of Block 24 on the CMS-1500 (02/12) claim form:

- The first two positions must be “N4” and the next eleven positions must be the NDC code comprised of eleven numeric digits.
- The next position must be a space.
- The next two positions must be one of the NDC Quantity Qualifiers identified in the element table above.
- The next few positions must be a numeric value, which quantifies the number of units, grams, milligrams or milliliters administered. No specific number of digits is required; however, the number submitted may not exceed 15 digits. If entering a whole number, do not use a decimal. Decimal points are allowed in the event they are needed. Do not use commas.

For example, when specifying 2 micrograms, use the “ME” qualifier and add “0.002” as the quantity.

When entering supplemental information for NDC, add in the following order qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity.

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The next three positions must be spaces.
The next two positions must be “ZZ” and the next few positions must be drug name.

Example:
N450242006101 ME1.25 ZZAvastin

C. Timely Filing Guidelines

Effective January 1, 2013, for BlueCare Tennessee, and October 1, 2013, for CoverKids, contracted and non-contracted Providers must submit all claims for medical services must be received within 120 days of the date of service, or for facilities, within 120 days from the date of discharge, or within 60 days from the date of the original rejection notice, whichever is later. For claims submitted by Physicians and other suppliers that include span dates of service (i.e., a “From” and “Through” date on the claim), the “From” date will be used for determining timely filing. However, in the case of retroactive BlueCare, TennCareSelect or CoverKids eligibility determinations, claims must be submitted and received within the latter of 120 days from the date of service or, for facilities, within 120 days from the date of discharge, or 120 days from the date BlueCare Tennessee receives notification from the Division of TennCare or CoverKids of the enrollee’s eligibility/enrollment.

Corrected Bills must be submitted and received within 120 days of the date of the original BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete (see Returned Claims and Processed Claims Needing Correction in this Manual). Exceptions to the 120-day timely filing period will be made for:

- recovery of overpayments as required under Section 6402 of the Affordable Care Act and TennCare policy;
- retrospective adjustments of a nursing facility’s per diem rates; or
- any other actions taken by BlueCare Tennessee after the date of the original BlueCare Tennessee remittance requiring the submission of a corrected bill by Provider.

In the above instances, corrected bills should be submitted within 120 days of notification by BlueCare Tennessee of the action.

BlueCare Tennessee, nor BlueCare or TennCareSelect Members will be obligated to pay such claims filed after expiration of the applicable time period, and such claims shall not be billed to the BlueCare Tennessee Member. BlueCare Tennessee will process in the normal course of its business all claims submitted by the Physician/Provider.

If BlueCare or TennCareSelect is secondary to a commercial insurer or Medicare, claims must be submitted and received within 120 days from the date the primary insurer’s remittance was produced.

Proof of timely filing for a returned paper claim is the black and white copy of the claim with error codes listed at the top of the claim that was returned to the Provider. Providers should always maintain a copy of the returned claim in case there is a question about timely filing. With new imaging technology, images of all rejected and accepted claims are maintained in BlueCare Tennessee’s archives for future reference. BlueCare Tennessee generates the 277CA Health Care Information Status Notification reports as proof of timely filing for electronically submitted BlueCare or TennCareSelect claims.

The electronic claims 277CA Health Care Information Status Notification supplies providers with one comprehensive report of all claims received electronically. This report should be maintained by the Provider for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Solutions at 423-535-5717 (Option 2), Monday through Thursday, 8 a.m. to 6 p.m. (ET) and Friday, 9 a.m. to 6 p.m. (ET). Note: Submission dates of claims filed electronically that are not accepted by BlueCross BlueShield of Tennessee due to transmission errors are not accepted as proof of timely filing.
D. Medicare/BlueCare or TennCareSelect Dual Eligible Members

BlueCare or TennCareSelect is not supplemental to Medicare’s primary payment. BlueCare Tennessee does not pay the Member’s coinsurance amounts after Medicare has paid primary. However, BlueCare Tennessee will pay primary benefits on supplies or services not covered by Medicare such as diapers, transportation, etc. BlueCare Tennessee does not require the submission of claims for Members who are classified as Medicare/Medicaid Dual Eligible or Uninsurable/Disabled with Medicare when the service rendered is a covered Medicare benefit. BlueCare or TennCareSelect should only be billed when Medicare has indicated that the service is non-covered and is the Member’s liability.

1. Medicare/Medicaid Dual Eligible Members

Claims filed electronically for Medicare/Medicaid dual eligible Members (Eligibility Class 17) should be filed to Medicare for primary payment. Medicare should crossover to the State of Tennessee for Medicare co-insurance amounts.

Paper claims filed for Medicare/Medicaid dual eligible Members (Eligibility Class 17) should be filed with Medicare for primary payment. After Medicare pays primary, the Provider must file the paper claim with Medicare’s Summary Notice (MSN) to the State of Tennessee for reimbursement of Medicare coinsurance amounts. Mail paper claims for secondary payment to:

**Professional Claims:**

Tennessee Bureau of Medicaid  
P.O. Box 460  
Nashville, TN 37202-0460

**Institutional Claims:**

Tennessee Bureau of Medicaid  
P.O. Box 470  
Nashville, TN 37202-0470

2. Uninsured/Uninsurable Dual Eligible Members

Uninsured/Uninsurable Members (Eligibility 77, also with Medicare) should be billed directly for any deductible/coinsurance amounts due after Medicare pays primary. BlueCare Tennessee will not pay these amounts; however, the Member is liable for their Medicare deductible/coinsurance.

If Providers file claims for non-Medicaid Members after Medicare has paid primary, the BlueCare Tennessee Remittance Advice (RA) will show patient liability as zero (0). However, the Provider may bill the Member for any Medicare deductible/coinsurance amounts. Medicare/Medicaid dual eligibles (Eligibility Classification 17) should not be billed for any Medicare deductible/coinsurance amounts, as these should crossover to the Tennessee Bureau of Medicaid for secondary payment.

E. Third Party Liability (TPL)

TPL is a provision in the BlueCare Tennessee contract that excludes payments for expenses covered by another medical plan. The purpose is to ensure that the other carrier’s payment does not exceed the BlueCare Tennessee allowable amount.

BlueCare and TennCareSelect is always the payer of last resort except for the following:

- Child Support Enforcement
- Crippled Children/Children Services
- TennCare Kids Services
- Prenatal or Preventive Pediatric Care

There are a number of commercial sources of information about TPL that are available to TennCare Providers and MCOs. TPL information can be found on the TennCare website at [https://www.tn.gov/tenncare/providers.html](https://www.tn.gov/tenncare/providers.html); however, this information is not intended to be an absolute and authoritative source of data about third party payers.

The following Division of TennCare policy addresses routine third party billing issues:

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1. Providers generally request TPL data from patients at the point of service. They should bill the third party payer before billing the MCO. Effective 8/1/15, all incontinence products will be provided by Medline. If the third party payer allows incontinence products, the third party payer network will dictate who the Member can utilize for services; however, if the third party payer does not consider incontinence supplies for benefits, the Member will need to utilize Medline.

If the probable existence of TPL for a particular enrollee has been determined by the MCO, the MCO may deny claims and return them to the Provider, with the instruction that the Provider should bill the third party payer first, unless the service is one that would fall under “pay and chase”. When denying a claim for TPL, the MCO must give the Provider its TPL data so that the Provider can appropriately submit his claim to the third party payer.

2. Sometimes the availability of TPL is not discovered until after a Provider claim has been paid. This discovery may be made by internal or external sources.

   a. Providers always have the discretion to refund payments they have received from TennCare or one of its contractors, such as the MCO, in order to pursue TPL. Once a Provider has refunded a payment received from TennCare or one of its contractors, the Provider may not resubmit another claim to TennCare or its contractor for the same service furnished to the same enrollee on the same date.

   b. If the MCO learns of the availability of TPL after it has made payment to the Provider, then the MCO may recover its payment to the Provider if all of the following conditions are met. This policy is not intended to affect the ability of the MCO to recover a duplicate payment when both the MCO and a third party have paid a claim to the same Provider for the same service.

   I. The claim involved was for a service delivered to an adult aged 21 and older, unless the adult is a pregnant woman who is receiving prenatal care;
   II. Less than nine months have passed since the date of service when there is a commercial insurer or Medicare involved;
   III. Prior to recoupment of its payment, the MCO notified the Provider with a refund request letter that included, at a minimum:

      • The name of the MCO;
      • The name of the Provider;
      • The list of claims or a reference to a remit advice date;
      • The reason for overpayment (Example: “Another commercial insurance carrier was the primary carrier at the time of service”);
      • The identification and contact information of the insurance carrier who was determined to have primary at the time of service, together with information about the insurance policy so that the provider can bill the insurance carrier;
      • A time period of at least forty-five (45) calendar days in which the Provider may return the MCO’s payment and/or appeal the decision;
      • Information about how and where to file an appeal with the MCO (phone number, contact information); and
      • A request that the Provider submit claims to the commercial insurance or Medicare if not already done.

   IV. When Providers choose to appeal the refund request letter from the MCO, they are given thirty (30) calendar days in addition to the forty-five (45) initial calendar days stated in the letter to provide sufficient documentation to the MCO prior to the MCO’s recovery of their payment. Providers should include in their appeals a copy of a denial from the primary carrier, if available, and

   V. The MCOs have ensured that there is a separate Service Line or Prompt for Provider Inquiries regarding these recoveries.

   c. The MCOs may not recoup payments made to a Provider when TPL is discovered unless all of the above criteria have been met.
The Division of TennCare implemented this policy and created a form for Provider use in requesting reclamation refunds from TennCare or a TennCare MCC. The form, TennCare Provider Refund Request form can be found on the TennCare web site, [https://www.tn.gov/content/dam/tn/tenncare/documents/medicaidreclamation.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/medicaidreclamation.pdf). Providers requesting a reclamation refund from the MCC (BlueCare/TennCare Select) should contact their assigned MCC Provider Relations Consultant.

All appeals should be submitted to the address listed below:

BlueCare Tennessee
Attention: Third Party Liability 2 Department
1 Cameron Hill Circle
Chattanooga, TN 37402

If an extension to the appeal time frame is required, the Provider should call the appropriate BlueCare or TennCare Select Provider Service line at 1-800-468-9736 (BlueCare) or 1-800-276-1978 (TennCare Select).

**Note:** The Centers for Disease Control and Prevention updated guidance for the Vaccines for Children (VFC) Program issued for 2017 regarding children dually enrolled in Medicaid and private insurance. However, until further notice, BlueCare Tennessee will follow the guidelines in the 2016 VFC Operations Guide as indicated below.

**Insured and Medicaid as Secondary Insurance:**
Situations occur where children may have private health insurance and Medicaid as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid. The parent is not required to participate in the VFC program. **The following are options for the parent and Provider:**

- **Option 1:** A Provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee.
- **Option 2:** A Provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.

**Pay and Chase Option** (Does not apply to CoverKids)
In accordance with the contractual agreement between BlueCare Tennessee, and the Division of TennCare, Providers may opt to file claims to BlueCare Tennessee as the primary carrier for the following services when the Member has been identified as having other insurance:

- TennCare Kids;
- Prenatal or preventive pediatric care including Vaccines for Children (VFC) services**; and
- All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

As the primary payer, BlueCare Tennessee will bill the responsible carrier for these services. However, in order to receive the higher reimbursement rate, it is to the Provider’s advantage to submit these claims to the other carrier first.

**Practitioners who participate in the VFC Program may use their VFC serum and file the claim with BlueCare or TennCare Select as the primary carrier. BlueCare or TennCare Select will pursue recovery of any liability from third parties.**

**The following lists processing Explanation Codes found on the Provider Remittance Advice (used for identifying Liability and Recovery):**

- C01 - Secondary to other insurance
- MSP – Secondary to Medicare
- EOB - Denied for explanation of benefits from other carrier
- MED – Denied for Medicare explanation of benefits
- WT8 - Denied due to non-compliance with primary payor’s contract provisions
Maintenance of Benefits

Coordination of benefits (COB) is a provision in the TennCare Program that excludes payments for expenses covered by another health care plan, or in cases of Subrogation, covered by an auto or home owner’s plan. Maintenance of benefits (MOB) is a variation of COB and is the process used by BlueCare Tennessee when processing secondary claims. The MOB process ensures that the combined payments of two or more health care programs do not exceed what would be paid under the TennCare Program. This is accomplished by determining the order of benefits to be provided by each health care plan.

BlueCare and TennCare Select are always the payers of last resort. When determining appropriate reimbursement for claims where a commercial carrier is primary third party payer, BlueCare Tennessee will only consider the other carrier’s actual payment amount when determining the third party payment. No Contractual discounts will be taken into consideration in this instance. If the other carrier’s payment amount is greater than or equal to BlueCare Tennessee’s allowable amount for the charges, BlueCare Tennessee will make no additional reimbursement on the claim.

If the third party payment is less than BlueCare Tennessee’s allowed amount, BlueCare Tennessee’s payment will equal the BlueCare Tennessee allowed amount minus the third party payment not to exceed the patient liability amount listed on the primary payer’s explanation of benefits. (Note: BlueCare Tennessee’s secondary payment will never exceed the amount listed as patient responsibility on the other carrier’s EOB.)

The methodology used to adjudicate claims where Medicare is primary is slightly different than the above.

BlueCare Tennessee will only consider eligible charges that are totally non-covered by Medicare and determined to be patient liability in considering whether reimbursement should be made on a claim. This is due to the fact that BlueCare Tennessee products are not supplemental policies to Medicare.

Where a Member’s Medicare Part A benefits are exhausted, BlueCare Tennessee will still require a copy of the Medicare Part B Summary Notice in order to determine appropriate reimbursement. BlueCare Tennessee will combine the Medicare Part B payment amount with the Medicare coinsurance and deductible amounts to determine the total third party payment. BlueCare Tennessee’s reimbursement on the claim will be equal to the BlueCare Tennessee allowable amount minus the third party payment.

F. General Billing and Reimbursement Information

Note: In accordance with federal and state requirements, all Providers requesting and providing services and seeking claims payment for BlueCare Tennessee and CoverKids Members are required to register for a Tennessee Medicaid ID number. This includes services rendered in relation to a medical emergency, rendered out of state or those rendered by an out-of-network Provider. This requirement applies to all primary and secondary Providers submitted on a claim as defined below:

- Professional Claims – Billing, Rendering, Ordering, Referring, Service Facility Location and Purchased Service
- Institutional Claims – Billing, Attending, Operating, Other Operating, Rendering provider and Service Facility Location

Claims submitted by and/or ordered by unregistered Providers will be ineligible for payment. Information concerning registration with the Division of TennCare can be located by going to the Provider Registration website at https://www.tn.gov/tenncare/providers/provider-registration.html.

Unless specified otherwise in this Manual, medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. For example:

- **CDT codes**—should be reported in accordance with the American Dental Association guidelines (e.g., CDT Manual).
- **CPT® codes**—should be reported in accordance with the American Medical Association guidelines including the CPT® Manual, CPT® Coding Changes, CPT® Assistant, CPT® Clinical Examples, CPT® Companion and other coding resources authorized by the American Medical Association.
- **HCPCS codes**—should be reported in accordance with the guidelines established by the Centers for Medicare & Medicaid Services (CMS) including, but not limited to, the HCPCS Manual, Federal Register, Center for Medicare & Medicaid Program Memorandums and Transmittals, Medicare Part B Bulletins.
- **ICD codes**—should be reported in accordance with the Department of Health and Human Services guidelines (e.g., ICD Manual).

CPT® is a registered trademark of the American Medical Association. Current Dental Terminology (CDT) is a trademark of the American Dental Association. Current Dental Terminology copyright© 2002, 2004 American Dental Association. All rights reserved. Both these terms are used throughout this Manual.

**Note:** The following update schedules (Numbers 2-5) reflect the addition, revision, or deletion of codes only. They do not relate to reimbursement.

2. Addition/Deletion/Revision CDT Codes

CDT codes are used to report diagnostic/preventive/restorative dental, endodontic, peridontic, prosthodontic, orthodontic, maxillofacial prosthetic, implant, and oral surgery services.

CDT is updated and maintained by the American Dental Association. CDT updates include addition, deletion, and/or revision of codes. Currently, CDT codes are subject to updates on a periodic basis (e.g., 01/01/1990, 01/01/1995, 01/01/2000, 01/01/2003, 01/01/2005). BlueCare Tennessee will implement updates to CDT codes according to the following schedule:

<table>
<thead>
<tr>
<th>Effective Date of Change by the American Dental Association</th>
<th>Effective Date of Change by BCBST (Date of Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>Addition</td>
</tr>
<tr>
<td></td>
<td>Revision</td>
</tr>
<tr>
<td></td>
<td>Deletion</td>
</tr>
<tr>
<td></td>
<td>January 1</td>
</tr>
<tr>
<td></td>
<td>January 1</td>
</tr>
<tr>
<td></td>
<td>January 1</td>
</tr>
<tr>
<td></td>
<td>January 1</td>
</tr>
</tbody>
</table>

In the event the American Dental Association modifies the schedule for coding updates, the BlueCare Tennessee schedule will be modified accordingly.

CDT codes billed prior to the effective date of the code will be rejected or returned by BlueCare Tennessee as an invalid code for the date of service.
Due to the short American Dental Association publication schedule, it is not possible for BlueCare Tennessee to notify providers of changes to CDT codes. The Provider is responsible for ensuring codes billed are valid for the date of service. CDT codes can be obtained from the American Dental Association.

3. Addition/Deletion/Revision CPT® Codes

CPT® (Current Procedural Terminology) codes are used to report physician, radiology, laboratory, evaluation and management, and other medical diagnostic procedures.

CPT® codes are updated and maintained by the American Medical Association. Currently, CPT® codes are subject to updates effective January 1 and July 1 of each year. CPT® updates include the addition, revision and/or deletion of codes.

BlueCare Tennessee will implement updates to CPT® codes according to the following schedule:

<table>
<thead>
<tr>
<th>Effective Date of Change by the American Medical Association</th>
<th>Effective Date of Change by BCBST (Date of Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>January 1</td>
</tr>
<tr>
<td>July 1</td>
<td>July 1</td>
</tr>
</tbody>
</table>

In the event the American Medical Association modifies the schedule for coding updates, the BlueCare Tennessee schedule will be modified accordingly.

CPT® codes billed prior to the effective date of the code will be rejected or returned by BlueCare Tennessee as an invalid code for the date of service.

Due to the short American Medical Association publication schedule, it is not possible for BlueCare Tennessee to notify providers of changes to CPT® codes. The Provider is responsible for ensuring codes billed are valid for the date of service.

CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT™ code updates may also be found on the American Medical Association website.

4. Addition/Deletion/Revision HCPCS Codes

HCPCS (HealthCare Common Procedural Coding System) codes are used to report transportation, medical supplies, durable medical equipment, injectable drugs, orthotic, prosthetic, hearing (e.g. hearing aids and accessories) and vision (e.g. frames, lens, contact lens, and accessories) services.

HCPCS codes are updated, maintained, and distributed by the Centers for Medicare & Medicaid Services (CMS) under the authority delegated by the Secretary of Health and Human Services (HHS). CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. Currently, HCPCS codes are subject to updates effective January 1, April 1, July 1, and October 1 of each year. HCPCS updates include addition, deletion, and/or revision of codes.

BlueCare Tennessee will implement updates to HCPCS codes according to the following schedule:

<table>
<thead>
<tr>
<th>Effective Date of Change</th>
<th>Effective Date of Change by BCBST (Date of Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>January 1</td>
</tr>
<tr>
<td>April 1</td>
<td>April 1</td>
</tr>
<tr>
<td>July 1</td>
<td>July 1</td>
</tr>
<tr>
<td>October 1</td>
<td>October 1</td>
</tr>
</tbody>
</table>
In the event the Department of Health and Human Services modifies the schedule for coding updates, the BlueCare Tennessee schedule will be modified accordingly. HCPCS codes billed prior to the effective date of the code will be rejected or returned by BlueCare Tennessee as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BlueCare Tennessee to notify Providers of changes to HCPCS codes. The Provider is responsible for ensuring codes billed are valid for the date of service.

HCPCS codes, HCPCS code updates, and HCPCS coding resources include, but are not limited to the following:

- Federal Register
- Centers for Medicare & Medicaid Program Memorandums and Transmittals
- Medicare Part B Educational Materials
- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines including, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Advisory Articles

*This document is located on the CGS Administrators, LLC website at http://www.cgsmedicare.com.
**This document is located on the Noridian Administrative Services, LLC (NAS) website at http://www.dmepdac.com.

5. Addition/Deletion/Revision ICD Codes

Effective 10/1/15, ICD-10 (International Classification of Diseases) codes should be filed in accordance with CMS guidance.

**ICD-10 includes:**

- ICD-10-CM codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- ICD-10-PCS codes are used to report prevention, diagnosis, treatment, and management

ICD-10 is updated and maintained by the Department of Health and Human Services. ICD-10 codes are subject to updates effective with discharges on or after April 1 and October 1 of each year. ICD-10 updates include addition, deletion, and/or revision of codes.

BlueCare Tennessee will implement updates to ICD codes according to the following schedule:

<table>
<thead>
<tr>
<th>Effective Date of Change</th>
<th>Effective Date of Change by BCBST (Date of Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Addition</td>
</tr>
<tr>
<td>April 1</td>
<td>April 1</td>
</tr>
<tr>
<td>October 1</td>
<td>October 1</td>
</tr>
</tbody>
</table>

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BlueCare Tennessee schedule will be modified accordingly.

ICD-10 codes billed prior to the effective date of the code will be rejected or returned by BlueCare Tennessee as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BlueCare Tennessee to notify Providers of changes to ICD-10 codes. The Provider is responsible for ensuring codes billed are valid for the date of service. ICD-10 codes can be obtained from the CMS website.
Note: ICD codes do not change as often for Behavioral Health Services, therefore the above update schedule may not apply.

6. Unlisted, Miscellaneous, Non-Specific, and Not Otherwise Classified (NOC) Procedures/Services

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) procedures/services should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

When an unlisted, miscellaneous, non-specific or not otherwise classified (NOC) code is reported, the procedure or service should be adequately described in order to determine eligibility and the appropriate maximum allowable. To make this determination, it may be necessary to provide one or more of the following types of supplemental information:

- A description of the procedure or service provided;
- Documentation of the time and effort necessary to perform procedure or service;
- An operative report for surgical procedures;
- An anesthesia flow sheet for anesthesia procedures;
- The name of the drug/immune globulin/immunization/vaccine/toxoid, National Drug Code (NDC), dosage, and number of units provided;
- The name of the manufacturer, name of product, product number, and quantity of durable medical equipment, medical supplies, orthotics and prosthetics; and
- For radiopharmaceuticals and contrast materials:
  - The name of the radiopharmaceutical and or contrast material, NDC, dosage and quantity; or
  - The manufacturer’s invoice listing the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage and number of units. If multiple patients are listed on the manufacturer’s/supplier’s invoice, the diagnostic radiopharmaceutical imaging agent or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

If an unlisted, miscellaneous, non-specific, or Not Otherwise Classified (NOC) CDT, CPT® or HCPCS code is reported without the needed supplemental information, the procedure or service will be non-covered or returned to the Provider. (See Completing CMS-1500 Claim Form – Block 24.)

Effective 2/1/06, regardless of the date of service, BlueCare Tennessee will begin disallowing services billed with an unlisted code when a specific CDT, CPT®, or HCPCS code is more appropriate.

7. Self-Administered Medications

Self-administered medications are defined as Oral, Topical, or self-administered injectable medications, including those indicated as Self-Administered Specialty Pharmacy Products. BCT does not reimburse these medications separately whether administered in the facility, office or dispensed for home use.

8. Final Reimbursement

When considering final reimbursement for services, procedures and items, BlueCare Tennessee considers several factors including, but not limited to:

- Member eligibility on the date of service
- Medical Necessity
- Applicable Member copayments and coinsurance
- Benefit plan exclusions/limitations
- Authorization/Out-of-Network referral requirements
- BCBST Medical Policy
- Code edits

9. Faxed, Photocopied and Altered Claims

In order to assure precise control, and timely and accurate payment of claims and to reduce the potential of fraud, BlueCare Tennessee will not accept claims faxed, photocopied or altered. Claims that do not meet the exception criteria below will be returned to the Provider:
All faxed and photocopied claims must be approved by BlueCare Tennessee Operations Manager or Supervisor or faxed at the request of BlueCare Tennessee;

All altered claims are returned to the Provider with an attachment stating BlueCare Tennessee does not accept claims that have been altered. Altered claims are claims with whiteout or which BlueCare Tennessee Operations determines are suspicious.

10. Policy for Quarterly Reimbursement Changes
This policy will be applicable when referenced in the Provider agreement or BCBST Quarterly Reimbursement Policy.

BlueCare Tennessee follows the BCBST Policy for Quarterly Reimbursement Changes.

Reimbursement changes applicable to this policy will be made according to the following schedule:

<table>
<thead>
<tr>
<th>Date Reimbursement Data is Published by Source</th>
<th>Date Change will be Applied by BCBST</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 to March 31</td>
<td>July 1</td>
</tr>
<tr>
<td>April 1 to June 30</td>
<td>October 1</td>
</tr>
<tr>
<td>July 1 to September 30</td>
<td>January 1</td>
</tr>
<tr>
<td>October 1 to December 31</td>
<td>April 1</td>
</tr>
</tbody>
</table>

Note: Codes with revisions may be added when appropriate, same as new codes, at any quarter with BCBST Coding and Reimbursement staff’s recommendation and proper approvals.

11. Quest Diagnostics Laboratory Billing Guidelines

Effective Oct. 1, 2012, BlueCare Tennessee entered into an arrangement with Quest Diagnostics Incorporated, to provide routine outpatient laboratory services to BlueCare, TennCareSelect and CoverKids Members* in both urban and rural areas across the state with the exception of those Covered Services described on the Exclusion List. Note: Inpatient laboratory services are not affected by this change.

Note: This arrangement does not affect BlueCare or TennCareSelect Members who are Undocumented Aliens or Medicare/Medicaid dual-eligible.

All outpatient laboratory testing for applicable Members covered by BlueCare Tennessee or CoverKids must be referred to Quest Diagnostics with the following limited exceptions:

1. Lab testing included on the approved Exclusion List
2. Proprietary lab tests without a comparable alternative through Quest Diagnostics Outpatient dialysis clinics
3. Outpatient dialysis clinics
4. Third Party Liability (TPL) claims
5. Emergency Room
6. Outpatient Observation
7. Inpatient Claims
8. Complications of Pregnancy Claims

BlueCare Tennessee’s arrangement with Quest is not all-inclusive. A detailed list of tests and corresponding CPT® codes excluded from the arrangement are found in Exclusion List on BlueCare Tennessee website.

Exclusion List of codes can be provided to BlueCare Tennessee’s TennCare Members by Physician offices, laboratories or hospitals other than Quest Diagnostics with their current fee schedule allowable reimbursement. BlueCare Tennessee periodically reviews and updates the codes on the Exclusion List.
Any changes, additions and/or deletions to the Exclusion List will be provided on the BlueCare Tennessee website at http://bluecare.bcbst.com/forms/Provider%20Information/Quest_Diagnostics-Exclusion_list.pdf.

To help ensure Quest Diagnostics remains the exclusive Provider under the terms of this Agreement, BlueCare Tennessee agrees it shall deny payments on all claims for Covered Services submitted by other suppliers or Providers except for those Covered Services described in Exclusion List. Denied claims will be returned to Provider with EX code WK0 – “This lab service is required to be performed by Quest Diagnostics”.

BlueCare Tennessee shall have the right to allow another Provider perform a Covered Service if comparable services are not available through Quest Diagnostics or if Quest Diagnostics cannot provide or arrange for the provision of Covered Services.

Healthcare Providers not currently using Quest Diagnostics for lab services will need to establish a Quest Lab Ordering and Reporting account. To request a Quest lab ordering and reporting account Providers should contact a Quest Diagnostics Physician Representative at 866-MY-QUEST (866-697-8378) Option 1, then Option 8 to set-up Quest’s lab ordering and reporting system in the office. Quest has dedicated representatives available to assist in establishing those accounts.

Providers may also contact their BlueCare Tennessee Provider Network Manager with questions/concerns related to this transition.

12. Billing Telehealth Originating Site Fees

BlueCare Tennessee reimburses for services rendered via Telehealth in accordance with BlueCare Tennessee, the Centers for Medicare & Medicaid Services (CMS), and TennCare Guidelines. Qualifying codes under BlueCare Tennessee are consistent with CMS, and TennCare guidance. By filing claims for encounters rendered via Telehealth, Providers are attesting that said claims were rendered according to these rules and guidelines.

Effective for dates of service 9/1/13 and after, Originating Sites may bill and receive a flat fee payment for Q3014 to be updated annually. These fees will be reimbursed when the Originating Site is not affiliated with the Distant Site Practitioner. For the Originating Site, code Q3014 is allowed for each qualifying unit of service received via Telehealth.

For Distant Site Practitioners, the qualifying encounter code should include a GT or 95 modifier to indicate the service was delivered via Telehealth.

Effective for dates of service 1/1/17 and after, the American Medical Association (AMA) created two (2) new codes that are considered eligible to be filed by the distant site practitioner as a Telehealth qualifying encounter and must be billed with a 95 modifier. These CPT® codes are 90863 and 96040. Although it is acceptable to render services via Telehealth from satellite to satellite as a convenience for multi-site Providers (as indicated by a GT or 95 modifier), it is not appropriate to bill Q3014 under these circumstances.

Effective for dates of service 1/1/17 and after, all Telehealth related services should be filed with Place of Service 02 for both the originating and distant site Providers.

Effective for dates of service 6/1/19 and after, any claims filed with services that cannot be related as a Telehealth service, per CMS and AMA guidelines and billed with Place of Service 02 for both the originating and distant site Providers may be denied for reimbursement.

On March 27, 2017, per State Legislative Law: SB 0195/HB 0338: Coverage for Telehealth Services Provided in Schools, the following applies to the Telehealth mandate provision for contracted Providers in...
addition to standard CMS requirements as an originating site Provider. The new law amends the
definition of “qualified site” to include a public elementary or secondary school staffed by health care services Provider (licensed in TN) where previously it only referenced a “school clinic.”
Q3014 billing will be audited and dollars recouped where billed outside policy and/or if billed when no corresponding GT or 95 modifier encounter is on file for the same date of service.


Providers are required to remain in compliance with all reporting requirements mandated by federal and state agencies. The Provider’s medical records, census documents and financial reporting should never change as a result of BlueCare Tennessee’s billing requirements. The billing of claims to BlueCare Tennessee is a contractual requirement for claim payment only and should never impact regulated reporting requirements.

The most common example of a non-standard billing requirement is billing for observation services when the admitting Physician has written an inpatient admission order, but BlueCare Tennessee only approved observation services. In this case, in order to receive payment for observation services, the Provider is required to bill BlueCare Tennessee as follows:

- Change the Type of Bill from inpatient to outpatient (13x)
- Convert the Room and Board revenue code to Observation (76x)

In this example, the Provider should make no changes to its medical records, continue to report the days as inpatient on their census reports and reflect charges under the Room & Board revenue codes on their financial system. This will keep the Provider in compliance with Medicare reporting but will allow payment under the contractual terms of their BlueCare Tennessee Provider Contract.

14. Emergency/Non-emergency

When the diagnoses filed are not on the Medical Emergency Diagnosis codes list, BlueCare Tennessee has implemented a prospective review process. This process will allow Providers to have their claims and medical records reviewed for medical emergency determination prior to the screening fee being paid. Providers may attach the complete emergency room medical record to the claim upon initial submission. The claim and record will be suspended for clinical review. Providers that have filed claims which have been processed and determined to be non-emergency, may either receive payment for the screening fee, or may appeal the denial by using the appeal process outlined in Section VIII. UM Program in this Manual. Claims for Members under age 2 and over age 65 will be reimbursed as a medical emergency.

Emergency Room (ER) Facility Claims

National Uniform Billing Committee (NUBC) guidelines limit the ER revenue codes (RCs) that can be submitted on the same claim with each other. For example, RC 0450 should not be submitted with any of the other ER RCs. Not following these guidelines may result in rejection of claim. NUBC information may be found at www.nubc.org/index.html.

All ER Facility Claims must be filed on a CMS-1450 claim form with:

- Outpatient Bill Type
- Revenue Code 0450 (Emergency Room) and the appropriate level of care CPT® code (e.g., 99281-99285 or 99291-99292)

Emergency level benefits are determined by:

- Principal diagnosis filed in Form Locator 67 on the CMS-1450 claim form; or
- Patient’s Reason for Visit Code filed in Form Locator 70 on the CMS-1450 claim form.
Note: When the Patient’s Reason for Visit Code is filed, this field should reflect the diagnosis (ICD code) supplied by the treating Practitioner that most closely describes the suspected emergency medical condition for which the Member sought care.

Special Fee (Refer to Section XVIII in this Manual for CoverKids)
A $10.00 or $50.00 Copay is charged to Medicaid BlueCare Members presenting to the emergency room. (The ER Copay amount is waived if the Member is admitted.)

Screening Fee
(Appplies to CoverKids effective 10/1/2017)
BlueCare will reimburse the lesser of the total covered charge or current fee schedule. The screening process should include or address chief complaint, brief history, vital signs and visualization of affected site. BlueCare Tennessee will automatically pay the screening fee when the ER claim (RC 0450) is billed for a medical non-emergency. Providers do not have to submit a separate claim with the screening RC 0451.

Copay charged to non-Medicaid BlueCare Members presenting to the ER for both emergency and non-emergency services will continue to apply. (Refer to Section XVIII. CoverKids, in this Manual.)

All screening fees must be filed on a CMS-1450 claim form with:
- Outpatient Bill Type, AND
- RC 0451 (Screening), when filed without ER Service (0450)
- CPT® code is not required
- Ancillary services will not be separately reimbursable
- Professional services will be disallowed if associated with screening

The following reimbursement rules apply:
- **ER Services:**
  ER services (RC 0450) do not require an authorization. Reimbursement will be based upon the current fee schedule. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

- **ER Services filed with Observation:**
  ER services (RC 0450) and Observation charges (RC 0762) are considered part of the Observation room charge and are not reimbursed separately. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

- **ER Services filed with Outpatient Surgery:**
  ER services (RC 0450) will be reimbursed in addition to the outpatient surgical reimbursement. Revenue codes should accurately reflect the type, place and resources utilized when reported with procedure codes. Procedures performed at bedside in the Emergency Room (ER) or in the Wound Care Clinic should not be reported with Operating Room revenue codes 0360 or 0361. Ancillary services are considered all-inclusive in the Outpatient Surgical Fee (OSF) reimbursement.

- **ER Services filed with Observation and Outpatient Surgery:**
  ER services (RC 0450) and Observation services filed with Outpatient Surgery services are considered all-inclusive in the Outpatient Surgery reimbursement and are not reimbursed separately. The Observation services will reimburse separately after the first six (6) hours. Ancillary services are considered all-inclusive in the OSF reimbursement.

- **Screening filed without ER Services:**
  A Screening (RC 0451) is reimbursed as an all-inclusive fee. Ancillary services are not reimbursed separately.

- **ER Services filed on an Inpatient CMS-1450 claim form (Inpatient setting):**
ER services filed on a CMS-1450 claim are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

**Note:** The BlueCare/TennCare Select/CoverKids emergency diagnosis code listings can be accessed on the Provider page of the company website at [http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Emergency-Services.html](http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Emergency-Services.html).

**Emergency Room (ER) Physician Claims**

All Emergency Related Professional Services must be filed on a CMS-1500 claim form with:
- Location Code 23
- Appropriate level of care CPT® code (e.g., 99281-99285 or 99291-99292)

**ER - Non-Emergency Professional fees** are based on contracted rate with reimbursement not to exceed $50.00 per claim. Other services filed with professional fee will not be reimbursed separately. *(Applies to CoverKids effective 10/1/2017)*

Emergency level benefits are determined by primary (diagnosis code A) and secondary (diagnosis code B) submitted in Block 21 of the CMS-1500 professional claim form.

The BlueCare/TennCare Select/CoverKids emergency diagnosis code listings can be accessed on the Provider page of the company website, [http://bluecare.bcbst.com](http://bluecare.bcbst.com).

Please refer to the Division of TennCare Budget Memo Guidelines located at the end of the General Billing and Reimbursement Information sub-section of this Manual or view the Budget Reduction Memo on our website for more information regarding ER Non-Emergency Professional fees.

**15. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)** *(Does not apply to CoverKids)*

**Note:** Effective 7/1/18, as part of the Division of TennCare annual budget reductions, for both professional and facility type Providers that supply these services, the Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies Maximum Fee Schedules have changed. As directed by the Division of TennCare, BlueCare Tennessee will utilize the April 2018 DMEPOS Fee Schedule as a maximum/ceiling for reimbursement unless a code has been specifically described in the budget reduction memo as having a different rate (i.e. back brace codes). The fee schedule listing can be found on our website at [http://bluecare.bcbst.com/Providers/DMEPOS_APR_Fee_Schedule_July%202018_Budget_Memo_Attachment.pdf](http://bluecare.bcbst.com/Providers/DMEPOS_APR_Fee_Schedule_July%202018_Budget_Memo_Attachment.pdf).

To clarify, these rates are intended to be a maximum fee schedule. If any services/codes are paying rates below the listed fee then no changes will be made to those fees. Please refer to the Division of TennCare Budget Memo Guidelines located at the end of the General Billing and Reimbursement Information sub-section of this Manual or view the budget reduction memo located on our website for more information.

**16. Division of TennCare Budget Memo Guidelines (Does Not Apply to Cover Kids)**

This section gives an overview of guidelines per topic. Please refer to the budget reduction memo located on our website for more details.

- **DME Maximum Fee Schedule**
  - Effective July 1, 2018, the MCOs must utilize the spreadsheet listed in the Budget Reduction Memo that is based on the April 2018 DMEPOS Fee Schedule as a maximum/ceiling for Provider rates unless a lower maximum rate has been specifically described in the budget reduction memo (e.g., back brace codes listed herein) or a lower rate is listed in the Provider’s contract.
• Cesarean and Vaginal Delivery Reimbursement (See Budget Memo Attachment C):

<table>
<thead>
<tr>
<th>Cesarean and Vaginal Delivery Reimbursement (see Attachment C for Crosswalk)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SFY 2012</strong></td>
</tr>
<tr>
<td>Effective July 1, 2011</td>
</tr>
<tr>
<td>Cesarean and vaginal deliveries will be reimbursed at the same rate effective July 1, 2011. MCOs are directed to increase their vaginal delivery rates by 17%. Additionally, MCOs are to pay the vaginal delivery rate for corresponding C-Section deliveries.</td>
</tr>
</tbody>
</table>

• Emergency Department Professional Fees
  - **ER - Non-Emergency Professional fees** are based on contracted rate with reimbursement not to exceed $50.00 per claim. Other services filed with professional fee will not be reimbursed separately.

• DME/Back Brace Reimbursement

<table>
<thead>
<tr>
<th>BACK BRACE REIMBURSEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective July 1, 2013</strong></td>
</tr>
<tr>
<td>HCPCS Code</td>
</tr>
<tr>
<td>L0637</td>
</tr>
<tr>
<td>L0631</td>
</tr>
<tr>
<td>L0627</td>
</tr>
</tbody>
</table>

• Implementation of Medicare standards for coverage of TENS and CLBP
• Diapers
  - Quantities over 200 per month require Prior Authorization.
• MRI
  - **Medical Necessity Criteria for Low Back Pain Diagnostic Testing** - Limit spinal (Cervical, Thoracic, and Lumbar) MRIs within the first eight weeks for a primary diagnosis of non-specific spine pain (ICD-9 codes 721.xx-724.xx) in the absence of other serious co-existing diagnoses.

• Benefit/Reimbursement limits for the following services (See Budget Memo attachment G):
  - **Facet/Medial Branch Block Injections**
    - Therapeutic Facet/Medial Block Injections are not covered.
    - Diagnostic Medial Branch Block Injections are covered as follows:
      - Limit of four per calendar year.
      - Must be performed by a Physician/Practitioner as required by Tennessee Acts 2012, Public Chapter No. 961/SB No. 1935.
  - **Trigger Joint Injections**
    - Limit of four (4) per muscle group in any period of six (6) consecutive months.
  - **Epidural Steroid Injections**
    - Limit of three (3) in any period of six (6) consecutive months (counting will start with the first shot on or after October 1, 2016).
- Limit of four (4) per muscle group in any period of six (6) consecutive months (counting will start with the first shot on or after October 1).

- Urine Drug Screens (Guideline changes per effective date)
  - Effective 1/1/19, the Division of TennCare updated the guidelines for urine drug screens CPT® codes 80305 and 80306 will be limited to 24 per Member per calendar year. This includes any combination of these codes. CPT® code 80307 will continue to be limited to 4 per Member per calendar year.
  - Prior to 1/1/19, CPT® codes 80305 and 80306 were limited to 12 per Member per calendar year, which included any combination of those codes. See the Budget Reduction Memo on the website for specific details and previous code changes (attachment G).

- TENS Unit – E0730 and CPT® Code 64550 – Non-covered for Chronic Low Back Pain.

- Assay Drug Testing (See Budget Memo Attachment H)
  - Effective October 1, 2015, Limit benefit frequency to two (2) services per year (each).

- Therapy Code List (See Budget Memo Attachment I)
  - Effective July 1, 2015, Limit benefit frequency to two (2) services per year (each).

- E&M/Therapy Same Day
  - Do not pay a provider for an Evaluation and Management code on the same date of service for which Therapy Services are paid to that same provider.

- Immunotherapy Guidelines – SFY2017 - Effective October 1, 2016
  The initial immunotherapy allergen treatment supply claim should be billed with a - GD modifier. Extract refill claims should be billed without the modifier. Initial and refill supplies shall be as medically necessary; however, payment should not be made for more than a three month supply at a time. Additionally, providers must follow practice guidelines according to the following:
  - Joint Task Force on Practice Parameters of the American Academy of Allergy, Asthma, and Immunology;
  - American College of Allergy, Asthma, and Immunology; and
  - Joint Council of Allergy, Asthma, and Immunology

- Compounded Prescriptions Effective July 1, 2015
  - TennCare will be implementing clinical criteria and will require prior authorization on compounded prescription medications to ensure that all compounded prescriptions are Medically Necessary.

- 1% Restoration of the SFY 2015 1% Budget Reduction as described in Attachment A – Effective July 1, 2017 (See Budget Reduction Memo Attachments B, D, E & F for applicable codes).

G. CMS-1500 Health Insurance Claim Form

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

The 1500 Health Insurance Claim Form is the basic paper claim for use by Practitioners and suppliers, and in some cases, for ambulance services.

All professional services should be filed on the CMS-1500 claim form or its electronic equivalent. These include:

- Professional Outpatient Services;
- Emergency Room Physician Fees must be filed with Location Code 23 (Emergency Room, Hospital)
- Clinic Visits (professional fees)
Note: BlueCare Tennessee follows the Centers for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) Web site, www.nucc.org. A sample copy of the CMS-1500 (02/12) claim form and block descriptions follow:
1. Sample Copy CMS-1500 (02/12) version claim form
2. CMS-1500 (02/12) Claim Form Block Descriptions:

<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td>Type of Plan</td>
</tr>
<tr>
<td>Block 1a</td>
<td>Insured’s ID Number (include three-letter alpha prefix)</td>
</tr>
<tr>
<td>Block 2</td>
<td>Patient’s Name</td>
</tr>
<tr>
<td>Block 3</td>
<td>Patient’s Date of Birth</td>
</tr>
<tr>
<td>Block 4</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>Block 5</td>
<td>Patient’s Address and Telephone Number</td>
</tr>
<tr>
<td>Block 6</td>
<td>Patient’s Relationship to Insured</td>
</tr>
<tr>
<td>Block 7</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>Block 8</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>Block 9</td>
<td>Other Insured’s Name</td>
</tr>
<tr>
<td>Block 9a</td>
<td>Other Insured’s Policy or Group Number</td>
</tr>
<tr>
<td>Block 9b</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>Block 9c</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>Block 10</td>
<td>Is Patient’s Condition Related To</td>
</tr>
<tr>
<td>Block 10d</td>
<td>Claim Codes</td>
</tr>
<tr>
<td>Block 11</td>
<td>Insured’s Policy Group or FECA Number</td>
</tr>
<tr>
<td>Block 11a</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>Block 11b</td>
<td>Other Claim ID</td>
</tr>
<tr>
<td>Block 11c</td>
<td>Insurance Plan Name or Program Name</td>
</tr>
<tr>
<td>Block 11d</td>
<td>Is There Another Health Benefit Plan</td>
</tr>
<tr>
<td>Block 12</td>
<td>Patient’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>Block 13</td>
<td>Insured’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>Block 14</td>
<td>Date of Current Illness, Injury, or Pregnancy</td>
</tr>
<tr>
<td>Block 15</td>
<td>Other Date</td>
</tr>
<tr>
<td>Block 16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>Block 17</td>
<td>Name of Referring Provider or Other Source</td>
</tr>
<tr>
<td>Block 17a</td>
<td>ID Number of Referring Provider or Other Source</td>
</tr>
<tr>
<td>Block 17b</td>
<td>NPI (National Provider Identifier) of Referring Provider</td>
</tr>
<tr>
<td>Block 18</td>
<td>Hospitalization Dates Related to Current Services</td>
</tr>
<tr>
<td>Block 19</td>
<td>Additional Claim Information</td>
</tr>
<tr>
<td>Block 20</td>
<td>Outside Lab?</td>
</tr>
<tr>
<td>Block 21</td>
<td>Diagnosis or Nature of Illness or Injury and ICD Ind</td>
</tr>
<tr>
<td>Block 22</td>
<td>Resubmission Code/Original Reference Number</td>
</tr>
<tr>
<td>Block 23</td>
<td>Prior Authorization Number (If Applicable)</td>
</tr>
<tr>
<td>Block 24A</td>
<td>Dates of Service</td>
</tr>
<tr>
<td>Block 24B</td>
<td>Place of Service</td>
</tr>
<tr>
<td>Block 24C</td>
<td>EMG (if emergency indicator required, enter “Y” for yes; leave blank if No)</td>
</tr>
<tr>
<td>Block 24D</td>
<td>CPT® or HCPCS code, modifiers</td>
</tr>
<tr>
<td>Block 24E</td>
<td>Diagnosis Pointer</td>
</tr>
<tr>
<td>Block 24F</td>
<td>Charges</td>
</tr>
<tr>
<td>Block 24G</td>
<td>Days or Units</td>
</tr>
<tr>
<td>Block 24H</td>
<td>EPSDT/Family Plan (TennCare Kids)</td>
</tr>
<tr>
<td>Block 24I</td>
<td>ID Qualifier</td>
</tr>
<tr>
<td>Block 24J</td>
<td>Rendering Provider ID Number</td>
</tr>
<tr>
<td>Block 25</td>
<td>Federal Tax ID Number or SSN</td>
</tr>
<tr>
<td>Block 26</td>
<td>Patient’s Account Number</td>
</tr>
<tr>
<td>Block 27</td>
<td>Accept Assignment</td>
</tr>
<tr>
<td>Block 28</td>
<td>Total Charge</td>
</tr>
<tr>
<td>Block 29</td>
<td>Amount Paid</td>
</tr>
<tr>
<td>Block 30</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>Block 31</td>
<td>Signature of Physician or Supplier</td>
</tr>
<tr>
<td>Block 32</td>
<td>Service Facility Location Information (address where service provided)</td>
</tr>
<tr>
<td>Block 32a</td>
<td>NPI (National Provider Identifier) of Service Facility</td>
</tr>
<tr>
<td>Block 32b</td>
<td>Non-NPI ID Number (unique identifier of the facility)</td>
</tr>
<tr>
<td>Block 33</td>
<td>Billing Provider Info and Telephone Number</td>
</tr>
<tr>
<td>Block 33a</td>
<td>NPI (National Provider Identifier) of Billing Provider in Block 33)</td>
</tr>
<tr>
<td>Block 33b</td>
<td>Non-NPI Number (unique identifier number of professional)</td>
</tr>
</tbody>
</table>
3. Data Elements Required for Submitting CMS-1500 Claims

To help avoid delays in receiving payments and unnecessary claim denials, all required information must be provided. The following lists data required when filing a CMS-1500 Claim Form. Note: (+) indicates if format or data is not valid, the claim will be rejected and returned to the Provider for correction and resubmission.

- +Insured’s I.D. number (include three-letter alpha prefix) Block 1a
- +Patient’s Name Block 2
- +Patient’s Date of Birth Block 3
- Insured’s Name Block 4
- Patient’s Address Block 5
- +Patient’s Relationship to Insured Block 6
- Another Health Plan Block 11d
- +Patient’s or Authorized Person’s Signature Block 12
- Insured’s or Authorized Person’s Signature Block 13
- +Date of Current Illness, Injury, or Pregnancy (LMP) Block 14
- Name of Referring Practitioner Block 17
- ID Number of Referring Provider Block 17a
- NPI (National Provider Identifier) of Referring Provider Block 17b
- +Diagnosis Block 21A-L
- +Dates of Service Block 24A
- +Place of Service Block 24B
- +Procedure Codes/Modifiers Block 24D
- +Diagnosis Pointer Block 24E
- +Charges Block 24F
- +Days/Units Block 24G
- +Federal Tax ID Number Block 25
- Patient’s Account Number Block 26
- +Total Charges Block 28
- Signature of Physician/Supplier Block 31
- +Billing Provider Info and Telephone Number Block 33
- +NPI (National Provider Identifier) of Billing Provider Block 33a
H. Completing CMS-1500 Claim Form

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

This section incorporates information from the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for the 08/05 Version into the BlueCare Tennessee Provider Administration Manual to help provide information on how to complete claim forms in compliance with the Centers for Medicare & Medicaid Services (CMS) regulations.

Included is a description of how each block of the CMS-1500 claim form is to be completed, what type of data should be entered, and the proper format for entering the data. Since detailed discussions or explanations of all the codes, rules and options go beyond the scope of this document, please refer any questions to the payor organization with which you are dealing.

Information and codes contained herein are accurate at the time of publication. Payor-issued mailings (newsletter, bulletins, etc.), workshop sessions and Provider Network Manager visits are sources of information for keeping this manual current.

To avoid delays in receiving payments and to avoid unnecessary claim denials, it is important that all of the required information is provided in the specified formats.

The printing specification sections are among the most important parts of this manual. The CMS-1500 form makes it possible for payors to continue adding the use of Optical Character Recognition equipment to their claims entry operations, making faster and more accurate claim payments possible. However, incomplete data, or data not properly aligned in the proper block will be rejected by OCR equipment, creating delays in processing or the return of the claim for correction and resubmission.

The following general instructions are intended to be a guide only for completing the CMS-1500 (02/12) claim form. Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the 1500 Claim Form.

The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) website, www.nucc.org.

1. General Instructions
   The form designated CMS-1500 is approved by CMS, TRICARE/CHAMPUS on Medical Services, and BlueCare Tennessee.

   A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

   ➢ Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
   ➢ “Super bills,” statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.
   ➢ The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
   ➢ The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
   ➢ Use standard fonts: do not intermix font styles on the same claim form.
   ➢ Do not use italics and script on the form.
   ➢ In completing all claim information COLOR OF INK should be as follows:

     1. Computer generated color of black
Use upper case (CAPITAL) letters for all alpha characters.
Do not use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
Enter information on the same horizontal plane.
Enter all information within the boundaries of the designated block.
Extraneous data (handwritten or stamped) may not be printed on the form.
Pin feed edges should be evenly removed prior to submission.

Form Alignment
The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled “PICA”. These boxes should be considered Line 1, Columns 1, 2 and 3, and Line 1, Columns 77, 78 and 79. Form alignment can be verified by printing “X’s” in these boxes.

Entering All Dates
In Blocks 3, 9B, and 11A please include a space between each digit. The blank space should fall on the vertical lines provided on the form.

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY
MM=month (01-12)
1 blank space
DD=day (01-31)
1 blank space
CC=century (20, 21)
YY=year (00-99)

The blank space should fall on the vertical lines provided on the form.
Do NOT exclude leading zeros in the date fields.
(Correct: January 1, 1924 = 01 01 24; Incorrect: 1124).

Note: New requirement for Block 24A. Omit spaces in Field 24A (date of service). By entering a continuous number, the date(s) will penetrate the dotted vertical lines used to separate month, day, and year. This is acceptable. Ignore the dotted vertical lines without changing font size.

For Block 24A

MMDDCCYY
MM=month (01-12)
DD=day (01-31)
CC=century (20, 21)
YY=year (00-99)

2. Physical Claim Form Specifications

While CMS-1500 claim forms can be ordered from the Government Printing Office, some providers may elect to deal with independent form vendors. All CMS-1500 claim forms must conform to the following print specifications:

PAPER
OCR bon - JCP25
20 pound
217 mm x 281mm (+ or - 2mm)
Cut square, corners 90 degrees (+ or -.025)

Rev 06/15

V-31
3. Form Contents and Description

Below is a description of each block on the form for completing each area.

**BLOCK 1 - TYPE OF PLAN**

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPVA</th>
<th>GROUP</th>
<th>FECA</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ (Medicare #)</td>
<td>☐ (Medicaid #)</td>
<td>☐ (Sponsor’s (SSN))</td>
<td>☐ (VA File #)</td>
<td>☐ (SSN or ID)</td>
<td>☐ (SSN)</td>
<td>☐ (ID)</td>
<td></td>
</tr>
</tbody>
</table>

Description: Place an “X” in the box to indicate the type of health insurance.

**BLOCK 1a - INSURED’S ID NUMBER**

1a. INSURED’S I.D. NUMBER (For Program in Item 1)

Description: The “Insured’s ID Number” is the identification number of the insured; this information identifies the insured to the payer. For TennCare Enrollees please provide the Member ID as shown on the Member’s ID card, including the three-letter alpha prefix (ZEC or ZED). This field allows for entry of 29 characters.

**BLOCK 2 – PATIENT’S NAME**

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)

Description: The “Patient’s Name” is the name of the person who received the treatment or supplies. List the patient’s full name, last name, first name, and middle initial exactly as it is shown on the TennCare ID card. If the patient used a last name suffix (e.g., Jr., Sr.) enter it after the last name and before the first name. Titles (e.g., Sister, Capt., Dr.) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for
hyphenated names. Do not use periods within the name. If the patient’s name is the same as the insured’s name (i.e., the patient is the insured), then it is not necessary to report the patient’s name.

If the claim is for a newborn and is being submitted under the mother’s ID then the ‘Patient’s Name’ will be the child’s name. Please refer to Section 26. Newborns in this manual for more details on submitting claims under the mother’s ID.

**BLOCK 3 – PATIENT’S BIRTH DATE, SEX**

<table>
<thead>
<tr>
<th>3. PATIENT’S BIRTH DATE</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM DD YY</td>
<td>M □ F □</td>
</tr>
</tbody>
</table>

Description: Enter the patient’s date of birth and sex. Enter the patient’s birth date in numerical format, using two (2) digits for the month, two (2) digits for the day and two (2) digits for the year for a total of six (6) digits. Check the box that indicates the sex of the patient.

To indicate SEX, place an “X” in the appropriate box to denote if the patient is male (M) or female (F).

**BLOCK 4 - INSURED’S NAME**

| 4. INSURED’S NAME (Last Name, First Name, Middle Initial) |

Description: The “Insured’s Name” identifies the person who holds the policy. This name should match the Member’s ID Card as well as the ‘Insured’s I.D. Number’ in Block 1a.

List the patient’s full last name, first name, and middle initial exactly as it is shown on the TennCare ID card. If the patient used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**BLOCK 5 – PATIENT’S ADDRESS (multiple fields)**

<table>
<thead>
<tr>
<th>5. PATIENT’S ADDRESS (No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY</td>
</tr>
<tr>
<td>ZIP CODE</td>
</tr>
</tbody>
</table>

Description: Enter the patient’s complete and current mailing address, including the number and street on the first line, the city and state on the second line, and a valid zip code and the telephone number (with area code) on the third line. If the patient lives in a nursing home or other extended care facility, provide the facility’s address.
BLOCK 6 – PATIENT RELATIONSHIP TO INSURED

6. PATIENT RELATIONSHIP TO INSURED

<table>
<thead>
<tr>
<th>Self □</th>
<th>Spouse □</th>
<th>Child □</th>
<th>Other □</th>
</tr>
</thead>
</table>

Description: The “Patient Relationship to Insured” indicates how the patient is related to the insured. Enter an “X” in the correct box to indicate the patient’s relationship to insured (Block 4). Only one box can be marked.

- “Self” would indicate the insured is the patient.
- “Spouse” would indicate the patient is the husband or wife or qualified partner, as defined by the insured’s plan.
- “Child” would indicate the patient is a minor dependent, as defined by the insured’s plan.
- “Other” would indicate the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured’s plan.

BLOCK 7 - INSURED’S ADDRESS (multiple fields)

7. INSURED’S ADDRESS (No., Street)

CITY                                                                 | STATE
ZIP CODE                                 | TELEPHONE (Include Area Code) ( )

Description: Enter the address (including street, city, state and zip code) and telephone number of the insured individual indicated in Block 4. If the address and telephone number are the same as the patient’s, as indicated in Block 5, enter the word “SAME”. If the insured’s address is “in care of” someone else, enter the “c/o” reference in the first three positions on the first line of the insured’s address.

BLOCK 8 – RESERVED FOR NUCC Use

8. RESERVED FOR NUCC USE

This field was previously used to report “Patient Status.” “Patient Status” does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

BLOCK 9 - OTHER INSURED’S NAME

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial )

Description: The “Other Insured’s Name” indicates there is a holder of another policy that may cover the patient.
If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank. When additional group health coverage exists, enter other insured’s full last name, first name, and middle initial of the enrollee in another health plan if it is different from that shown in Item Number 2. If the patient used a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

**BLOCKS 9a-9d - COORDINATION OF BENEFITS**

- **a. OTHER INSURED’S POLICY OR GROUP NUMBER**
  
  Description: The “Other Insured’s Policy or Group Number” identifies the policy or group number for coverage of the insured as indicated in Item Number 9. Do not use a hyphen or space as a separator within the policy or group number.

- **b. RESERVED FOR NUCC USE**
  
  Description: This field is reserved for NUCC use, do not use.

- **c. RESERVED FOR NUCC USE**
  
  Description: This field is reserved for NUCC use, do not use.

- **d. INSURANCE PLAN NAME OR PROGRAM NAME**
  
  Description: The “Insurance Plan Name or Program Name” identifies the name of the plan or program of the other insured as indicated in Item Number 9.

**BLOCK 10 – IS PATIENT’S CONDITION RELATED TO**

- **10. IS PATIENT’S CONDITION RELATED TO:**
  - **a. EMPLOYMENT? (CURRENT OR PREVIOUS)**
    - YES □
    - NO □
  - **b. AUTO ACCIDENT?**
    - YES □
    - NO □
  - **c. OTHER ACCIDENT?**
    - YES □
    - NO □
  - **PLACE (State)**

Description: Indicate whether the patient’s condition is related to his or her employment and is applicable to one (1) or more of the services described in Block 24. If the patient’s condition is related to employment, put an “X” in the “YES” box and indicate whether it is related to the patient’s “current” or “previous employment by circling the appropriate term.
If the injury or illness is related to an automobile accident, place an “X” in the “YES” box. Enter the date of the accident in Block 14 in six (6)-digit format. If the patient’s condition is related to an “other accident”, place an “X” in the “YES” box. Enter the date of the accident in Block 14.

File the claim with the other insurer as the primary payer (Block 11). Once a response (either a payment or denial notice) is received from the primary insurer, file the secondary claim with TennCare MCO.

**BLOCK 10d – CLAIM CODES**

<table>
<thead>
<tr>
<th>10d. CLAIM CODES (Designated by NUCC)</th>
</tr>
</thead>
</table>

**Description:** The “Claim Codes” identify additional information about the patient’s condition or the claim.

When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC. Please refer to the most current instructions from the public or private payer regarding the need to report claim codes.

- For Workers’ Compensation Claims – Condition Codes are required when submitting a bill that is a duplicate or an appeal. The Original Reference Number must be entered in the “Original Ref. No. area of Block 22 for these situations. Do not use Condition Codes when submitting a revised or corrected bill.

- This field will allow for the entry of 19 characters; when reporting more than one (1) code, enter three (3) blank spaces and then the next code.

**BLOCK 11 - INSURED’S POLICY GROUP OR FECA NUMBER**

<table>
<thead>
<tr>
<th>11. INSURED’S POLICY GROUP OR FECA NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>a. INSURED’S DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM : DD : YY</td>
</tr>
<tr>
<td>SEX M □ F □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. OTHER CLAIM ID (Designated by NUCC)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>c. INSURANCE PLAN NAME OR PROGRAM NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES □ NO □ If yes, complete item 9, 9a and 9d</td>
</tr>
</tbody>
</table>

**Description:** The “Insured’s Policy, Group, or FECA Number” is the alphanumeric identifier for the health, auto, or other insurance plan coverage. Enter the Group No. as it appears on Member’s ID card. If Block 4 is completed, then this field should also be completed.

**Note:** The number submitted in this field should not be the same number submitted in Block 1a Insured’s I.D. Number and entering the same number in both these fields will result in the claim being returned unprocessed.
BLOCK 11a - INSURED’S DATE OF BIRTH

Description: The “Insured’s Date of Birth, Sex” is the birth date and gender of the insured as indicated in Block 1a. Enter the six (6)-digit date of birth (MM/DD/YY) of the insured and an “X” to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

BLOCK 11b — OTHER CLAIM ID (Designated by NUCC)

This Block should be left blank for TennCare claims.

BLOCK 11c — INSURANCE PLAN NAME OR PROGRAM NAME

Description: The “Insurance Plan Name or Program Name” is the name of the plan or program of the insured as indicated in Block 1a.

BLOCK 11d — IS THERE ANOTHER HEALTH BENEFIT PLAN?

Description: “Is There Another Health Benefit Plan?” indicates that the patient has insurance coverage other than the plan indicated in Block 1. Only one (1) box can be marked. If marked “YES”, complete Blocks 9, 9a, and 9d.

BLOCK 12 — PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE (INFORMATION RELEASE/GOVERNMENT ASSIGNMENT)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________________________________________ DATE ______________________

Description: The “Patient’s or Authorized Person’s Signature” indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim. Enter “Signature on File,” “SOF,” or legal signature. When legal signature, enter date signed in 6-digit (MM/DD/YY) or 8-digit format (MM/DD/YYYY) format. If there is no signature on file, leave blank or enter “No Signature on File.”

BLOCK 13 — INSURED’S OR AUTHORIZED PERSON’S SIGNATURE (NON-GOVERNMENT PROGRAMS)

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________________________________________________

Description: The “Insured’s or Authorized Person’s Signature” indicates that there is a signature on file authorizing payment of medical benefits. Enter “Signature on File,” “SOF,” or legal signature. If there is no signature on file, leave blank or enter “No Signature on file.”

Rev 09/15
BLOCK 14 — DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY

14. DATE OF CURRENT: ILLNESS, INJURY OR PREGNANCY (LMP)
   MM  DD  YY
   QUAL.

Description: The “Date of Current Illness, Injury, or Pregnancy (LMP)” is used to report the onset of acute symptoms for a current illness or condition or that the services are related to the patient’s pregnancy.

There are only two valid qualifiers for this block, these qualifiers and their guidelines are listed below.

- 431 (Onset of Current Symptoms or Illness) – This information is required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service. The date entered in this block should not be the same as the date of service, if the dates entered are the same the claim will be returned unprocessed.

- 484 (Last Menstrual Period) – This information is required when, in the judgment of the Provider, the services on this claim are related to the patient's pregnancy.

Enter the six (6)-digit (MM│DD│YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical, dotted line.

BLOCK 15 — OTHER DATE

15. OTHER DATE.
   QUAL.  MM  DD  YY

Description: The “Other Date” identifies additional date information about the patient’s condition or treatment. Enter another date related to the patient’s condition or treatment.

Note – Qualifier 454 Initial Treatment should be used to submit the date of initial treatment for spinal manipulation, physical therapy, occupational therapy, speech language pathology, dialysis, optical refractions, pregnancy, etc. Qualifier 444 First Visit or Consultation should not be used to report the initial date of treatment as it is only to be used to report the date of first contact for Property & Casualty claims. At this time Property & Casualty claims are not applicable to BlueCare Tennessee therefore submitting Qualifier 444 First Visit or Consultation will cause the claim to be returned unprocessed.

BLOCK 16 — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
   FROM  MM  DD  YY  TO  MM  DD  YY

Description: “Dates Patient Unable to Work in Current Occupation” is the time span the patient is/or was unable to work.

If the patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit format (MM/DD/YYYY) date must be shown for the “from-to” dates the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.
BLOCK 17 — NAME OF REFERRING PROVIDER OR OTHER SOURCE

BLOCK 17a — OTHER ID NUMBER

BLOCK 17b — NPI NUMBER

<table>
<thead>
<tr>
<th>17.NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
<th>17a.</th>
<th>17b.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NPI</td>
</tr>
</tbody>
</table>

Description: This Block is to report the referring, ordering, supervising Provider who referred, ordered, or supervised the service(s) or supply(s) on the claim.

To indicate the role of the Provider being reported, enter the appropriate qualifier to the left of the vertical, dotted line. The name of the referring, ordering, or supervising Provider should be entered to the right of the vertical, dotted line. If multiple Providers are involved, enter one provider using the following priority order:

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

BLOCK 17a — OTHER ID NUMBER

Description: The Other ID (non-NPI ID) number of the referring, ordering, or supervising Provider. Enter the appropriate qualifier to the left of the vertical, dotted line.

BLOCK 17b — NPI NUMBER

Description: The NPI number refers to the HIPAA National Provider Number.

Note: If any information is entered in either Block 17 or 17a then an NPI must be included in this block or the claim will be rejected back to the Provider unprocessed.

BLOCK 18 — HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |
| MM | DD | YY | MM | DD | YY |
| FROM | TO |

Description: The “Hospitalization Dates Related to Current Services” refers to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

Enter the inpatient 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank. This date is when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
BLOCK 19 — ADDITIONAL CLAIM INFORMATION

Description: “Additional Claim Information” identifies additional information about the patient’s condition or the claim. Data identified in this block is currently not used to process claims.

NOTE – Data supplied in this block will not be utilized.

BLOCK 20 — OUTSIDE LAB? $CHARGES

Description: “Outside lab? $Charges” indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.

Complete this field when billing for purchased services by entering an X in “YES” mark indicates the reported service was provided by an entity other than the billing provider (for example, services subject to Medicare’s anti-markup rule). A “NO” mark or blank indicates that no purchased services are included on the claim.

If “YES” is marked, enter the purchase price under “$Charges” and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.

When entering the charge amount, enter the amount in the field to the left of the vertical line. Enter number right justified to the left of the vertical line. Enter 00 for cents if the amount is a whole number. Do not use dollar signs, commas, or a decimal point when reporting amounts. Negative dollar amounts are not allowed. Leave the right-hand field blank.

BLOCK 21 — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

Description: The “ICD Indicator” identifies the version of the ICD code set being reported. The “Diagnosis or Nature of Illness or Injury” is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim.

The Diagnosis Codes entered in Block 21 are now referenced as by alpha (A-L) pointers rather than numeric pointers. Enter codes left justified on each line to identify the patient’s diagnosis and/or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than twelve (12) ICD diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative in this block.
BLOCK 22 — RESUBMISSION CODE/ORIGINAL REFERENCE NUMBER

22. RESUBMISSION CODE
    CODE  ORIGINAL REF. NO.

Description: This block is to be used when submitting a corrected claim. “Resubmission” means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

- A Resubmission Code should be filed in the first portion of Block 22. The valid values for this field are “7” Replacement of prior claim and “8” Void/Cancel of prior claim. These codes should be left-justified in the box so that they will be processed correctly.
- The original claim number issued to the claim being corrected should be filed in the Original Ref. No., portion of Block 22.
- This block is not intended for use for original claim submissions.
- Failure to include the proper “Resubmission Code” and “Original Ref. No.” may result in a claim rejection or denial.

BLOCK 23 — PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER

Description: The “Prior Authorization Number” is the payer assigned number authorizing the service(s).

Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. Do not enter hyphens or spaces within the number.

NOTE – For Air Ambulance services submitted on the CMS-1500 claim form the Pick-up Location Zip Code should be submitted in Block 23. Multiple Zip Codes should not be submitted in this block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct Zip Code is five (5) numeric digits; if a (9) nine-digit Zip Code is submitted the last four (4) digits are ignored. If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.

BLOCK 24A. — 24J. SUPPLEMENTAL INFORMATION

The following lists qualifier codes and description of supplemental information that can be entered in the shaded lines of Block 24:

- Anesthesia information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)

Description: To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.
The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- ML Milliliter
- GR Gram
- UN Unit
- ME Milligram

More than one supplemental item can be reported in the shaded lines of Block 24. Enter the first qualifier and number/code/information at Block 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)

Example:
N450242006 101 ME1.25 ZZ Avastin

Note: Supplemental information entered in shaded area will be ignored if a valid qualifier does not precede the data.

The following examples define how to enter different types of supplemental information in Block 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services:

Example 1: Anesthesia Services, when payment based on minutes as units

Example 2: Anesthesia Services, when payment based on 15-minute units

Example 3: Unspecified Code

Example 4: NDC Code
### BLOCK 24A — DATE(S) OF SERVICE

**Description:** This block indicates the beginning and ending dates of service for the entire period reflected by the procedure code, using six (6) digit formats, excluding all punctuation. Do not use slashes between dates. If the date or month is a single-digit, precede it with a zero (0). Make sure the dates shown are no earlier than the date of the current illness shown in Block 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the “from” and “to” dates are the same.

Up to 6 services (line items) may be reported on any one document. If more than 6 services (line items) need to be reported, additional forms must be completed.

The six (6) service lines in Block 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.

The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Supplemental information can only be entered with a corresponding, completed line and is to be placed in the shaded section of 24A through 24G.

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM</td>
<td>DD</td>
</tr>
<tr>
<td>MM</td>
<td>DD</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### BLOCK 24F. — CHARGES, DAYS OR UNITS, EPSDT, ID QUALIFIER, AND RENDERING PROVIDER ID NUMBER

<table>
<thead>
<tr>
<th>F. $CHARGES</th>
<th>G. DAYS OR UNITS</th>
<th>H. EPSDT Family Plan</th>
<th>I. ID QUAL</th>
<th>J. Rendering Provider Id. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
</tr>
</tbody>
</table>
## BLOCK 24B — PLACE OF SERVICE

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>pharmacy</td>
</tr>
<tr>
<td>02</td>
<td>telehealth</td>
</tr>
<tr>
<td>03</td>
<td>school</td>
</tr>
<tr>
<td>04</td>
<td>homeless shelter</td>
</tr>
<tr>
<td>05</td>
<td>indian health service; free-standing facility</td>
</tr>
<tr>
<td>06</td>
<td>indian health service; provider-based facility</td>
</tr>
<tr>
<td>07</td>
<td>tribal 638; free-standing facility</td>
</tr>
<tr>
<td>08</td>
<td>tribal 638; provider-based facility</td>
</tr>
<tr>
<td>09</td>
<td>prison/correctional facility</td>
</tr>
<tr>
<td>10</td>
<td>unassigned</td>
</tr>
<tr>
<td>11</td>
<td>office</td>
</tr>
<tr>
<td>12</td>
<td>home</td>
</tr>
<tr>
<td>13</td>
<td>assisted living facility</td>
</tr>
<tr>
<td>14</td>
<td>group home</td>
</tr>
<tr>
<td>15</td>
<td>mobile unit</td>
</tr>
<tr>
<td>16</td>
<td>temporary lodging</td>
</tr>
<tr>
<td>17</td>
<td>walk-in retail health clinic</td>
</tr>
<tr>
<td>18</td>
<td>place of employment/worksite</td>
</tr>
<tr>
<td>19</td>
<td>off-campus outpatient hospital</td>
</tr>
<tr>
<td>20</td>
<td>urgent care facility (distinct from hospital ER/office/clinic)</td>
</tr>
<tr>
<td>21</td>
<td>inpatient hospital (non-psychiatric)</td>
</tr>
<tr>
<td>22</td>
<td>on-campus outpatient hospital</td>
</tr>
<tr>
<td>23</td>
<td>emergency room, hospital</td>
</tr>
<tr>
<td>24</td>
<td>ambulatory surgical center</td>
</tr>
<tr>
<td>25</td>
<td>birthing center</td>
</tr>
<tr>
<td>26</td>
<td>military treatment facility</td>
</tr>
<tr>
<td>27-30</td>
<td>unassigned</td>
</tr>
<tr>
<td>31</td>
<td>skilled nursing facility</td>
</tr>
<tr>
<td>32</td>
<td>nursing facility</td>
</tr>
<tr>
<td>33</td>
<td>custodial care facility</td>
</tr>
<tr>
<td>34</td>
<td>hospice</td>
</tr>
<tr>
<td>35-40</td>
<td>unassigned</td>
</tr>
<tr>
<td>41</td>
<td>ambulance, land</td>
</tr>
<tr>
<td>42</td>
<td>ambulance, air or water</td>
</tr>
<tr>
<td>43-48</td>
<td>unassigned</td>
</tr>
<tr>
<td>49</td>
<td>independent clinic</td>
</tr>
<tr>
<td>50</td>
<td>federally qualified health center</td>
</tr>
<tr>
<td>51</td>
<td>inpatient, psychiatric facility</td>
</tr>
<tr>
<td>52</td>
<td>psychiatric facility, partial hospitalization</td>
</tr>
<tr>
<td>53</td>
<td>community mental health center</td>
</tr>
<tr>
<td>54</td>
<td>intermediate care facility, individuals with intellectual disabilities</td>
</tr>
<tr>
<td>55</td>
<td>residential substance abuse facility</td>
</tr>
<tr>
<td>56</td>
<td>psychiatric residential treatment center</td>
</tr>
<tr>
<td>57</td>
<td>non-residential substance abuse treatment facility</td>
</tr>
<tr>
<td>58-59</td>
<td>unassigned</td>
</tr>
<tr>
<td>60</td>
<td>mass immunization center</td>
</tr>
<tr>
<td>61</td>
<td>comprehensive inpatient rehabilitation facility</td>
</tr>
<tr>
<td>62</td>
<td>comprehensive outpatient rehabilitation facility</td>
</tr>
<tr>
<td>63-64</td>
<td>unassigned</td>
</tr>
<tr>
<td>65</td>
<td>end stage renal disease treatment facility</td>
</tr>
<tr>
<td>66-70</td>
<td>unassigned</td>
</tr>
<tr>
<td>71</td>
<td>state or local public health clinic</td>
</tr>
<tr>
<td>72</td>
<td>rural health clinic</td>
</tr>
<tr>
<td>73-80</td>
<td>unassigned</td>
</tr>
<tr>
<td>81</td>
<td>independent laboratory</td>
</tr>
<tr>
<td>82-98</td>
<td>unassigned</td>
</tr>
<tr>
<td>99</td>
<td>other, place of service</td>
</tr>
</tbody>
</table>

**Description:** Enter the appropriate two (2) -digit Place of Service Code for each item used or service performed. If services were provided in the emergency department, use code 23. If services were provided in an urgent care center, use code 22. If services were rendered in a hospital, clinic, laboratory or other facility, show the name and the address of the facility in Block 32.
BLOCK 24C — EMG (This field was originally titled “Type of Service”. “Type of Service” is no longer used and has been eliminated)

Description: If required, enter Y for “Yes” or leave blank if “No” in the bottom, unshaded area of the field. An emergency medical condition means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES

Description: Enter the CPT® code applicable to the services, procedures or supplies rendered. Include the CPT® modifiers when necessary. The codes and modifiers selected must be supported by medical documentation in the patient’s record. Link each CPT® code with the appropriate ICD code listed in Block 21 by line item. See Block 24E for further instruction. The codes and modifiers selected must be supported by medical documentation in the patient’s record. Link each HCPCS code with the appropriate ICD code listed in Items 21 and 24E. Enter the specific procedure code without a descriptive narrative. If no specific procedure codes are available that fully describe the procedure performed, and an “unlisted” or “not otherwise classified” procedure code must be used, include the narrative description in description in the shaded area for Block 24. See Block 24 Supplemental Information for further instruction.

Modifiers: A modifier is a 2-digit combination of numeric, alpha and/or numeric that may be added to a procedure code. Modifiers may be used to indicate that:

- A service or procedure is either a professional or technical component.
- A service or procedure was performed by more than one Practitioner and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A service or procedure was provided more than once.

BLOCK 24E — DIAGNOSIS POINTER

Description: The “Diagnosis Pointer” is the line letter (A-L) from Block 21 that relates to the reason the service(s) was performed.

In Block 24E, enter the diagnosis code reference letter (A-L) as shown in Block 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter (A-L) for each service should be listed first, other applicable services should follow. Numeric entries in Block 24E are no longer valid for this block and will cause the claim to be rejected back to the Provider unprocessed.

Enter each applicable diagnosis at the line item level. If the service is for three diagnosis codes, it should be keyed as ABC. Do not enter A-C.
BLOCK 24F — CHARGES

Description: Enter the amount charged by the Practitioner for each of the services or procedures listed on the claim. If multiple occurrences of the same procedure are being billed on the same line, indicate the inclusive dates of service in Block 24A. List the separate charge for each service in this block and the number of units or days in Block 24G. Do not bill a flat fee for multiple dates of service on one line.

BLOCK 24G — DAYS OR UNITS

Description: This Block shows the number of days or units of procedures, services or supplies listed in Block 24D. This block is most commonly used to report multiple visits, units of supplies, minutes of anesthesia and oxygen volume. The number “1” must be entered if only one service is performed. For some services (e.g., hospital visits, tests, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it is compared with the inclusive dates of service listed in Block 24A. Days usually are reported when the patient has been hospitalized. When billing radiology services, do not provide the number of X-ray views. However, when the same radiology procedure is performed more than once on the same day, the number of times should be shown in this block. Anesthesia claims must be reported in minutes. (Refer to Anesthesia Specifics for billing procedures).

BLOCK 24H — EPSDT (TennCare Kids)/FAMILY PLAN

Description: Enter “Y” for “YES” and “N” for “NO” to indicate that TennCare Kids services were provided. TennCare Kids applies only to children who are under 21 and receive medical benefits through public assistance.

BLOCK 24I — ID QUALIFIER (This field was originally titled “EMG”. However, “EMG” is now located in Block 24C)

Description: If the Provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. (See Block 17a for listing of qualifiers and numbers.)

The rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where substitute Provider (Locum Tenens) was used, enter that Provider’s information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b.

BLOCK 24J —RENDERING PROVIDER ID # (This field was originally titled “COB”)

Description: The individual rendering the service is reported in 24J. The original fields for 24J and 24K have been combined and re-numbered as 24J. Enter the non-NPI number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

The rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute Provider (locum tenens) or delegated was used, enter that Provider’s information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b. If a Nurse Practitioner, Physician’s Assistant, CRNA, etc., is billing a service that does not require supervision, then the actual rendering professional’s ID number can be filed as the rendering Provider in Block 24J with a group name and NPI submitted as the Billing Provider in Blocks 33-33a.
Note: When Block 24J, line item rendering Provider, is used:
- It should be an individual, never a group identity;
- It must be the individual who performed the service(s); and
- It must be an identity that BlueCare Tennessee recognizes as a valid Provider of health care services.

Multiple rendering Providers may NOT be submitted on the same claim. Block 24J and 33a do NOT have to match.

**BLOCK 25 — FEDERAL TAX I.D. NUMBER OR SSN**

<table>
<thead>
<tr>
<th>25. FEDERAL TAX I.D. NUMBER</th>
<th>SSN</th>
<th>EIN</th>
</tr>
</thead>
</table>

**Description:** Enter the Federal Tax I.D. Number of the physician or supplier. The number may be the Social Security Number (SSN) or the Federal Tax ID Number/Employee Identification Number (EIN). Designate whether number listed is SSN or EIN by placing an “X” in the appropriate box.

**BLOCK 26 — PATIENT’S ACCOUNT NUMBER**

<table>
<thead>
<tr>
<th>26. PATIENT’S ACCOUNT NO</th>
</tr>
</thead>
</table>

**Description:** “The Patient’s Account Number” is the identifier assigned by the Provider. NUCC and NUBC guidelines require the submission of the patient’s unique number assigned by the Provider to facilitate retrieval of the individual’s account of services containing the financial billing records and any postings of payment.

This field is required and will hold up to fourteen (14) alphanumeric characters. Special characters (e.g. (*) Asterisk, (^) Carat, (:) Colon, (~) Tilde, etc.) should not be used. Claims submitted without a “Patient Account No.” on or after April 1, 2015, will be rejected back to the Provider unprocessed.

**BLOCK 27 — ACCEPT ASSIGNMENT?**

<table>
<thead>
<tr>
<th>27. ACCEPT ASSIGNMENT?</th>
</tr>
</thead>
</table>

**Description:** If the Physician or supplier agrees to accept the charge allowed by TennCare as the full payment for the service, place an “X” in the “YES” box. This establishes this claim as an assigned claim. A TennCare participating physician must always check the “YES” box.
BLOCK 28 — TOTAL CHARGE

28. TOTAL CHARGE

$ | 

Description: Enter the dollars and cents omitting the dollar sign. Also, verify that this amount equals the total of the charges listed in Block 24F. To bill a Medicare secondary payer (MSP) claim, bill the full amount of the charges in this block. Do not report the difference between what the primary payer paid and the total charges or the allowed amounts. Attach a copy of the primary payer’s Remittance Advice (RA) that contains the payment information.

BLOCK 29 — AMOUNT PAID

29. AMOUNT PAID

$ | 

Description: This block must be completed when billing TennCare as the secondary payer. Enter the amount paid by the patient for covered services only using dollars and cents, omitting the dollar sign. Unless an agreement exists between the provider and payor, this block must be manually completed.

BLOCK 30 — RESERVED FOR NUCC USE

This field was previously used to report “Balance Due.” “Balance Due” does not exist in 5010A1, so this field has been eliminated.

This field is reserved for NUCC use. The NUCC will provide instructions for any use of this field.

BLOCK 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

INCLUDING DEGREES OR CREDENTIALS

(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED | DATE

Description: Enter the signature of the physician or supplier, or a representative, and the date the claim form was signed in eight (8)-digit format. The provider or his or her authorized representative must sign the provider’s name, or an approved facsimile stamp may be used. Type the provider’s full name below the signature or stamp. Do not enter the name of an association or corporation in this block. (Computer-generated/printed provider’s name of “Signature on File” will also be accepted here.)

Rev 06/15
BLOCK 32 — SERVICE FACILITY LOCATION INFORMATION

32. SERVICE FACILITY LOCATION INFORMATION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>NPI</td>
</tr>
</tbody>
</table>

Description: Enter the name and address of the facility where the services were rendered if they were rendered in a hospital, clinic, laboratory, or any facility other than the patient’s home or Physician’s office. A complete address includes the zip code, which allows carriers to determine the correct pricing locality for purposes of claims payment. When the name and the address of the facility where services were rendered is the same as the name and address shown in Block 33, enter the word “SAME”.

BLOCK 32a — NPI #

Description: Enter the NPI number of the service facility location.

BLOCK 32b — OTHER ID #

Description: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

BLOCK 33 — BILLING PROVIDER INFO & PH #

33. BILLING PROVIDER INFO & PH # ( )

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>NPI</td>
</tr>
</tbody>
</table>

Description: Enter the Provider’s or supplier’s billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

BLOCK 33a — NPI #

Description: Enter the NPI number of the billing Provider.

Note: When Block 33, Billing Provider is used, submit as follows:

- The individual NPI for the Billing Provider in Block 33a only when the Provider is an individual, unincorporated entity;
- Enter the supervising Physician as the billing Provider only when billing delegated services or locum tenens; and
- Otherwise, the Group NPI should always be filed as the Billing Provider.

BLOCK 33b — OTHER ID #

Description: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
I. Specific CMS-1500 Claim Form Billing and Reimbursement Guidelines

Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and medical policy.

1. Anesthesia Billing and Reimbursement Guidelines

Anesthesia services provided by an anesthesiologist or CRNA can be categorized as follows:

- Administration of anesthesia
- Qualifying circumstances for anesthesia such as:
  - Anesthesia for patient of extreme age, under one year or over seventy
  - Anesthesia complicated by utilization of total body hypothermia
  - Anesthesia complicated by utilization of controlled hypotension
  - Anesthesia complicated by emergency conditions
- Unusual forms of monitoring such as:
  - Intra-arterial
  - Central venous
  - Swan-Ganz
  - Transesophageal echocardiography (TEE)
- Post operative pain management-placement of epidural
- Post operative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration

Anesthesia services provided by an anesthesiologist or CRNA should be billed according to the following guidelines:

- Anesthesia services provided by an anesthesiologist or CRNA should be billed on a CMS-1500/ANSI 837P.
- Anesthesia services provided on different dates of service should be billed on separate claim forms.

- Administration of Anesthesia

**Paper Claim Form - Block 24D (CPT®/HCPCS)**

Administration of anesthesia must be billed using the most appropriate CPT® code 00100-01999 in effect for the date of service.

The anesthesia administration code includes the following:

- The usual preoperative and postoperative visits
- The administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of non-invasive monitoring (EKG, EEG, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).

**Note:** Services for the administration of anesthesia will be rejected or returned if billed using a CPT® code in the range 10021-69979.

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.
Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24D (First Modifier)**
Anesthesia services must be billed using the most appropriate anesthesia modifier. Acceptable anesthesia modifiers are as follows:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than 4 concurrent procedures</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
</tr>
<tr>
<td>QY</td>
<td>Anesthesiologist medically directs one CRNA</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
</tr>
</tbody>
</table>

Anesthesia administration services billed without an acceptable anesthesia modifier will be rejected or returned.

**Paper Claim Form - Block 24D (Second Modifier)**
A physical status modifier may be billed in the second modifier field. Acceptable physical status modifiers are as follows:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
</table>

**Paper Claim Form - Block 24G (Days or Units)**
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

**Note:** Anesthesia time must be reported in minutes. Anesthesia time must not be converted to units. Conversion to units will result in an incorrect payment.

- **Qualifying Circumstances**

**Paper Claim Form - Block 24D (CPT®/HCPCS)**
Qualifying circumstances for anesthesia may be billed with the following CPT® codes as applicable:
BlueCare Tennessee  
Provider Administration Manual

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age, under one year and over seventy</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency condition</td>
</tr>
</tbody>
</table>

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

**Paper Claim Form - Block 24D (First Modifier)**
Do not bill qualifying circumstances with an anesthesia modifier (e.g. AA, AD, QK, QX, QY, or QZ) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24D (Second Modifier)**
Do not bill qualifying circumstances with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

**Paper Claim Form - Block 24G (Days or Units)**
Qualifying circumstances should be billed with one number of service.
Do not bill anesthesia minutes in this field.

➤ **Unusual Forms of Monitoring**

**Paper Claim Form - Block 24 D (CPT®/HCPCS)**
Unusual forms of monitoring may be billed using the most appropriate CPT® or HCPCS code.

**Paper Claim Form - Block 24D (First Modifier)**
Do not bill unusual forms of monitoring with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24D (Second Modifier)**
Do not bill unusual forms of monitoring with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

**Paper Claim Form - Block 24G (Days or Units)**
Unusual forms of monitoring should be billed using the appropriate number(s) of service.
Do not bill anesthesia minutes in this field.

➤ **Postoperative Pain Management-Placement of Epidural**
If operative procedure was performed or ends under general anesthesia and epidural is placed for postoperative pain management purposes, placement of the epidural may be billed as follows:

**Paper Claim Form - Block 24 D (CPT®/HCPCS)**
Postoperative pain management-placement of epidural should be billed using the most appropriate CPT® code.

For 2004 dates of service, the most appropriate CPT® code are 62318 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast for either localization or epidurography, of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution; epidural or subarachnoid; cervical or thoracic) or 62319 (Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast for either localization or epidurography, of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution; epidural or subarachnoid; lumbar sacral).

For dates of service other than 2004, refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.
**BlueCare Tennessee**  
**Provider Administration Manual**

**Paper Claim Form - Block 24D (First Modifier)**  
Do not bill postoperative pain management-placement of epidural with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24D (Second Modifier)**  
Do not bill postoperative pain management-placement of epidural with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

**Paper Claim Form - Block 24G (Days or Units)**  
Postoperative pain management-placement of epidural should be billed using the appropriate number(s) of service.

Do not bill anesthesia minutes in this field.

- **Postoperative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration**

Postoperative pain management-daily hospital management should only be billed for postoperative days. Postoperative pain management-daily hospital management should not be billed on the same day as the operative procedure.

Billing of postoperative pain management-daily hospital management billed on the same day as the operative procedure may result in delay in reimbursement, rejection of charge or return of claim.

Postoperative pain management-daily hospital management should be billed as follows:

**Paper Claim Form - Block 24 D (CPT®/HCPCS)**  
Postoperative pain management-daily hospital management should be billed using the most appropriate CPT® code.

For 2004 dates of service, the most appropriate CPT® code is 01996 (Daily hospital management of continuous epidural or continuous subarachnoid drug administration).

For dates of service other than 2004, refer to the CPT® book in effect for the date of service for the most appropriate code.

**Paper Claim Form - Block 24D (First Modifier)**  
Do not bill postoperative pain management-daily hospital management with an AA, AD, QK, QX, QY, or QZ modifier as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24D (Second Modifier)**  
Do not bill postoperative pain management-daily hospital management with a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6).

**Paper Claim Form - Block 24G (Days or Units)**  
Postoperative pain management-daily hospital management should be billed using one number of service for each day of postoperative pain management.

Do not bill anesthesia minutes in this field.
Anesthesia Reimbursement Guidelines

Reimbursement for eligible anesthesia services provided by an anesthesiologist or CRNA are categorized as follows:

- **Administration of anesthesia**
  - **Qualifying circumstances for anesthesia such as:**
    - Anesthesia for patient of extreme age, under one year or over seventy
    - Anesthesia complicated by utilization of total body hypothermia
    - Anesthesia complicated by utilization of controlled hypotension
    - Anesthesia complicated by emergency conditions
  - **Unusual forms of monitoring such as:**
    - Intra-arterial
    - Central venous
    - Swan-Ganz
    - Transesophageal echocardiography (TEE)
  - **Post operative pain management-placement of epidural**
  - **Post operative pain management-daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration**

Maximum allowable for administration of anesthesia performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of covered charges or the following formula:

\[
\text{Maximum Allowable} = (\text{Basic Value} + \text{Time Unit} + \text{Physical Status Unit Value}) \times \text{Conversion Factor} \times \text{Percentage}
\]

**Basic Values**
Basic Values are based on the American Society of Anesthesiologist (ASA) Relative Value Guide in effect for the date of service. In the event there is a delay in the publication of the ASA guide, BCT will default to the CMS base unit values until the ASA guide becomes available.

Updates to the Basic Values will be made in accordance with the BCBST Quarterly Reimbursement Changes Policy.

Updates to the Basic Values may result in increases and decreases in maximum allowable.

**Note:** BlueCare Tennessee follows the BCBST Policy for Quarterly Reimbursement Changes.

**Time Unit**
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision. In cases where there is a break in anesthesia (e.g. due to technique used, delay of surgeon, relief, multiple start and stop times, etc.), time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time in minutes will be converted to time units by BlueCare Tennessee as indicated below:

Fractional time units will be rounded up to the next whole unit (i.e. 1.1 units will be rounded to 2 units, 1.4 units will be rounded to 2 units, 1.5 units will be rounded to 2 units, 1.6 units will be rounded to 2 units, 1.9 units will be rounded to 2 units). Anesthesia time does not apply to CPT® code 01996.
Physical Status Unit Values
Additional base units for physical status will be allowed as follows:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
<td>0</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>1</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>2</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>0</td>
</tr>
</tbody>
</table>

Time Units, Conversion Factors and Percentages
Conversion Factors and Percentages follow:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Time Unit</th>
<th>Conversion Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
<td>15</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than 4 concurrent procedures</td>
<td>15</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals</td>
<td>15</td>
<td>Refer to contract</td>
<td>50%</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>15</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
<td>15</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
<td>15</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Medical Supervision of Anesthesia Services
Reimbursement for medical supervision of anesthesia services, (e.g. anesthesia modifier AD), will be limited to three (3) Basic Values, one (1) unit of time, and 100 percent of the conversion factor for the anesthesiologist.

Qualifying Circumstances for Anesthesia
Maximum allowable for qualifying circumstances for anesthesia performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of Covered charges or the following formula:

\[
\text{Maximum Allowable} = \text{Unit Value} \times \text{Conversion Factor}
\]

The following are the Unit Values for qualifying circumstances for anesthesia:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age, under one year and over seventy</td>
<td>1</td>
<td>Refer to contract</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency condition</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

Unusual Forms of Monitoring
Maximum allowable for unusual forms of monitoring such as intra-arterial, central venous, Swan-Ganz, and transesophageal echocardiography (TEE) provided in conjunction with anesthesia administration will be based on the lesser of Covered charges or the Professional Maximum Allowable Fee Schedule.
Postoperative Pain Management-Placement of Epidural

Maximum allowable for placement of epidural for postoperative pain management services performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of Covered charges or the Professional Maximum Allowable Fee Schedule.

Postoperative Pain Management-Daily Hospital Management of Epidural (Continuous) or Subarachnoid (Continuous) Drug Administration

The maximum allowable for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) is based on the lesser of Covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following is the Unit Value for post operative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>01996</td>
<td>Daily Management of epidural or subarachnoid drug administration</td>
<td>3</td>
<td>Refer to contract</td>
</tr>
</tbody>
</table>

Reimbursement is limited to no more than three postoperative days of daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration.

2. Obstetric Anesthesia

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code. In those cases with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean delivery on the following day, dates of service for both codes should have the same from and through date, (i.e. from beginning of anesthesia through to the completion).

Obstetric anesthesia services involving more than one Provider (e.g. two Physicians or two CRNA’s) for the same episode are to be submitted on a single claim with the date of delivery as the date of service.

3. Reimbursement Guidelines for Administration of Regional or General Anesthesia Provided by a Surgeon

Administration of regional or general anesthesia provided by a surgeon should be reported by appending modifier 47 (Anesthesia by Surgeon) to the appropriate procedure code in accordance with CPT® guidelines. Reimbursement for administration of regional or general anesthesia provided by a surgeon is included in the reimbursement for the surgical or other procedure and is not separately reimbursed. Reimbursement for the surgical or other procedure is based on the professional maximum allowable fee schedule. CPT® Modifier 47 has no effect on the maximum allowable.

This policy applies to administration of regional or general anesthesia provided by a surgeon billed with CPT® modifier 47 on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

4. Reimbursement Policy for Moderate Conscious Sedation

Moderate (conscious) sedation provided by the same Physician performing the diagnostic or therapeutic service that the sedation supports.
Moderate (conscious) sedation provided by a Physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

For DOS prior to 12/31/2016: Moderate Conscious Sedation codes are identified in the CPT® codebook with a special symbol for Moderate Conscious Sedation. Reimbursement for Moderate (Conscious) Sedation will be paid in accordance to the CMS and Appendix G.

For DOS beginning 01/01/2017
Reimbursement details for Moderate (Conscious) Sedation and related services can be found on the company website at www.bcbst.com/sedationcode.

5. OB/GYN Services

Bill in accordance with CPT® and American College of Obstetrics and Gynecologists (ACOG) coding guidelines in effect for Date of Service.

6. Reimbursement Guidelines for Bundled Services Regardless of the Location of Service

Under Resource Based Relative Value Scale (RBRVS) methodology, Medicare considers reimbursement for certain codes bundled regardless of the location of service. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “B”. These documents are located at www.cms.gov.

Unless specified otherwise in this policy, BlueCare Tennessee considers codes published by Medicare with a Status Code “B” as bundled regardless of the location of service. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “B” will be made in accordance with the BlueCross Policy for Quarterly Reimbursement Changes. This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>96040</td>
<td>1/1/2007</td>
<td>Eff. 3/1/13 – Reimbursement is considered bundled with the service to which it is incident with the exception of Genetic Counseling providers who are credentialed and contracted with BlueCross BlueShield of Tennessee.</td>
</tr>
<tr>
<td>98961</td>
<td>1/1/2006</td>
<td>Eff. 3/1/13 – Reimbursement is considered bundled with the service to which it is incident with the exception of Genetic Counseling providers who are credentialed and contracted with BlueCross BlueShield of Tennessee.</td>
</tr>
<tr>
<td>98962</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99050</td>
<td>1/1/2000</td>
<td>Reimbursement is considered bundled with the service to which it is incident when the service is provided in all locations of service with the exception of the Practitioner’s office (place of service 11). When the location of service is the Practitioner’s office, code will be eligible for reimbursement in an effort to encourage Practitioners to provide services after office hours when necessary and discourage the inappropriate use of the emergency room by Members.</td>
</tr>
<tr>
<td>99078</td>
<td>1/1/2000</td>
<td>Reimbursement is considered bundled with the service to which it is incident with the exception of when the service is approved through an eligible BlueCare Tennessee initiative.</td>
</tr>
<tr>
<td>99100</td>
<td>1/1/2000</td>
<td>Reimbursement is considered bundled with the service to which it is incident with the exception of when the service is performed by an anesthesiologist or CRNA related to anesthesia administration.</td>
</tr>
<tr>
<td>99116</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99135</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99366</td>
<td>1/1/2008</td>
<td>Eff. 3/1/13 – Reimbursement is considered bundled with the service to which it is incident with the exception of Genetic Counseling providers who are credentialed and contracted with BlueCross BlueShield of Tennessee.</td>
</tr>
</tbody>
</table>
7. Reimbursement Guidelines for Bundled Services when the Location of Service is the Practitioner’s Office

Under Resource Based Relative Value Scale (RBRVS) methodology, Medicare considers reimbursement for certain codes bundled when the location of service is the Physician’s office. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “P”. These documents are located at www.cms.gov. Unless specified otherwise in the policy, BlueCare Tennessee considers codes published by Medicare with a Status Code “P” as bundled when the location of service is the Practitioner’s office. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “P” will be made in accordance with the BlueCross/BlueCare Tennessee Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business when the location of service is the Practitioner’s office (i.e., place of service 11).

Exception:
When the location of service is the Practitioner’s office (place of service 11), HCPCS code V2520 is eligible for reimbursement.

8. Professional and Technical Components for Radiology, Laboratory and Other Diagnostic Procedures

Per the BlueCross/BlueCare Tennessee Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures, reimbursement will be limited to procedures where a 26-professional component or TC-technical component modifier is appropriate per the Medicare Physician Fee Schedule Data Base, Federal Register or National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals in effect for the date of service. These documents are located at www.cms.gov.

Reimbursement will be based on the lesser of total covered charges or the maximum allowable fee schedule allowance for the procedure.

Note: For technical component for professional services performed in a facility, BlueCare Tennessee DRG and outpatient case rates paid to a facility include any technical component for professional services provided for facility patients. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist or other Provider. Payment is not made under the Physician fee schedule for technical component services provided for facility patients. The Member cannot be held liable in these cases, as reimbursement for technical component services is part of the all-inclusive global payment made to facilities. Should a facility choose to partner with a Provider for the technical component associated with the facility services, the facility will be responsible for payment of the Provider. MedAdvantage claims should continue to be billed consistent with CMS guidelines.

9. Reimbursement Guidelines for Multiple Procedures

This policy applies to multiple procedures billed on a CMS-1500/ANSI-837P for all BCBST/BlueCare Tennessee business.

The maximum allowable for eligible multiple procedures billed for the same patient on the same date of service by the same provider will be based on the multiple procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents are located at http://www.cms.gov/.

The final allowable for eligible multiple procedures will be subject to the lesser of provision found in the facility’s contract, if applicable.
Codes published by Medicare National Physician Relative Value Fee Schedule with a multiple procedure indicator "3" will be administered by BCBST/BlueCare Tennessee based on the guidelines for multiple procedure indicator "2".

Refer to Exhibit A for a summary of the percentages of the base allowable that will be applied for each multiple procedure indicator and procedure code rank.

The determination of the primary procedure when multiple procedures are billed for the same patient on the same date of service by the same provider will be based on the procedure with the highest allowed amount according to the appropriate base fee schedule. All base allowables will be evaluated for each line billed. The procedure with the highest dollar amount according to the fee schedule will be considered as the primary procedure.

An exception will be made to this reimbursement methodology when an Intrauterine Device (IUD) is inserted at the time of delivery.

This policy applies to multiple procedures billed on a CMS-1500/ANSI-837P for all BCBST/BlueCare Tennessee business.

Exhibit A – Reimbursement Guidelines for Multiple Procedures Follow:

<table>
<thead>
<tr>
<th>MPFSRvrF Indicator</th>
<th>Procedure Rank</th>
<th>Percentage</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1st</td>
<td>100%</td>
<td>No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule for the procedure.</td>
</tr>
<tr>
<td>0</td>
<td>2nd +</td>
<td>100%</td>
<td>Standard payment adjustment rules for multiple procedures apply.</td>
</tr>
<tr>
<td>2</td>
<td>1st</td>
<td>100%</td>
<td>Standard payment adjustment rules for multiple procedures apply.</td>
</tr>
<tr>
<td>2</td>
<td>2nd</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>3rd</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4th</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>5th</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6th +</td>
<td>IC</td>
<td>Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>1st</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2nd</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3rd</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>4th</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5th</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>6th +</td>
<td>IC</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1st</td>
<td>100%</td>
<td>Concept does not apply.</td>
</tr>
<tr>
<td>9</td>
<td>2nd+</td>
<td>100%</td>
<td>Concept does not apply.</td>
</tr>
</tbody>
</table>

10. Reimbursement Guidelines for Bilateral Procedures

This policy applies to bilateral procedures billed for the same patient on the same date of service by the same Provider on a CMS-1500/ANSI-837P for all BCBST/BlueCare Tennessee business.

The maximum allowable for eligible bilateral procedures billed for the same patient on the same date of service by the same provider will be based on the bilateral procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents are located at: [http://www.cms.gov/](http://www.cms.gov/).
The final allowable for eligible bilateral procedures will be subject to the lesser of provision found in the facility’s contract, if applicable.

Per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples are when, but not limited to:

- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm),
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”.

Therefore, sometimes it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit
- a single line with modifier 50 and 1 unit; and/or
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

Reimbursement Guidelines for Bilateral Procedures can be found on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

11. Assistant-at-Surgery Billing Guidelines and Reimbursement Policy

The following guidelines apply:

**Assistant-at-Surgery Services provided by a Physician:**

- Assistant-at-surgery services provided by a physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon), 82 (Assistant Surgeon when qualified resident surgeon not available) to the procedure code.
- The 80, 81, or 82 modifier should not be used to report assistant-at-surgery services provided by a physician assistant, nurse practitioner or clinical nurse specialist.
- BlueCare Tennessee will reimburse for eligible assistant-at-surgery services provided by a Physician based on the lesser of covered charges or 16 percent of the maximum allowable fee schedule amount for all BCBST/BlueCare Tennessee networks.

**Assistant-at-Surgery Services provided by a Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist:**

- Assistant-at-surgery services provided by a physician assistant, nurse practitioner, or clinical nurse specialist should be reported by appending the Level II HCPCS modifier AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery).
- Assistant-at-surgery services provided by non-physicians (e.g., physician assistants, nurse practitioners and clinical nurse specialists) are considered ancillary support.
- Reimbursement for assistant-at-surgery services provided by non-physicians is included in the reimbursement to the licensed practitioner for services provided in the physician’s office or in the reimbursement to the facility for services provided in an inpatient or outpatient setting.
- The maximum allowable for procedures reported with an AS modifier will be $0.00.
- Such services will be reported on the remittance with a W72 or NP remark code and will be denied provider liability. Participating and non-participating providers will not be permitted to bill the Member for the difference between the charge and the BlueCare Tennessee maximum allowable for the AS modifier as the physician assistant, nurse practitioner or clinical nurse specialist should be compensated directly by the supervising Physician or facility.
12. Reimbursement Guidelines for Procedures Performed by Two Surgeons

Reimbursement for eligible procedures performed by two surgeons will be based on the lesser of covered charges or 62.5 percent of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125 percent of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the Provider in accordance with standard coding and billing guidelines. Each co-surgeon from a different specialty performs a distinct portion of the complete procedure and reports the exact same surgical procedure code with the 62 modifier. Each surgeon must dictate his/her own operative report. BCBST/BlueCare Tennessee uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPS/CPT® code.

This policy applies to procedures performed by two surgeons billed with CPT® modifier 62 on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

13. Reimbursement Guidelines for Procedures Performed on Infants Less than 4kg

Procedures on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work. According to the Current Procedural Terminology, CPT® Manual, this modifier may only be appended to procedures/services listed in the 20000 through 69999 code series.

According to presentations made by representatives of the American Pediatric Surgical Association (APSA), there are many definite exclusions of CPT® codes within the Surgical series of CPT® codes. The APSA consistent with CPT® guidelines, note the following exclusions, whereas Modifier 63 should not be appended to any CPT® codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections and any of the codes listed in the Summary of Codes Exempt from Modifier 63. These codes will be in an Appendix and have instructions listed below the code “(Do not report modifier 63 in conjunction with …)”.

If the documentation supports additional reimbursement for the indication of procedure performed on an infant less than 4 kg representing physician work and complexity over and above the services included in the standard base code, then reimbursement for eligible services will be based on the lesser of charges or up to 130% of the contracted rate for that procedure. Documentation should include the procedure code, weight of the neonate or infant, time required to perform the procedure, anesthesia flow sheet/record, and any unusual condition/outcome for that particular procedure (complexity).

Services billed with CPT® modifier 63 without the required supplemental documentation will not be considered for additional reimbursement.

This policy applies to those appropriate CPT® codes with a Modifier 63 billed on a CMS-1500/ANSI- 837P for all BlueCross/BlueCare Tennessee business.

14. Reimbursement Guidelines for Unusual Procedural Services

When the service(s) provided is greater than that usually required for the listed procedure, the service may be reported by appending CPT® modifier 22 to the procedure code.

Documentation supporting the unusual procedural service such as descriptive statements identifying the unusual circumstances, operative report, pathology report, progress notes, and/or office notes must be submitted by the provider in order to determine if the service is eligible for additional reimbursement.

Services billed with CPT® modifier 22 without the required supplemental documentation will not be considered for additional reimbursement.
If the documentation supports additional reimbursement for the unusual procedural service, reimbursement for eligible services will be based on the lesser of covered charges or up to 130 percent of the base maximum fee schedule allowable.

This policy applies to unusual procedural services billed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

15. Reimbursement Guidelines for Screening Test for Visual Acuity

According to Current Procedural Terminology (CPT®), a “screening test of visual acuity must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an evaluation and management service of the eye, it is a diagnostic examination and not a screening test.”

The American Medical Association created code 99173 (Screening test of visual acuity, quantitative, bilateral) at the request of the American Academy of Ophthalmology in association with the American Academy of Pediatrics to enable pediatricians to bill for performing a visual screening test to ascertain whether future referral for visual care is needed. The code was also developed to electronically track visual screenings for pediatric patients to support proposed Utilization Review Accreditation Commission (URAC) efforts.

According to the American Academy of Pediatrics, a screening test of visual acuity is typically provided in conjunction with a preventive medicine service, which includes external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination.

Effective 10/1/05 date of service and after, code 99173 will be reimbursed separately and no longer bundled with the service to which it is incident. However, the screening test for code 99173 will be limited to one (1) visit per year for Members under age 21 years per direction from the State of Tennessee, Division of TennCare.

Sources


16. Reimbursement Guidelines for Visual Function Screening

According to Current Procedural Terminology (CPT®), code 99172 may be used to report visual function screening which includes automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, and color vision by pseudoisochromatic plates, and field of vision. Code 99172 may also include all or some screening of the determination(s) for contrast sensitivity vision under glare. This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (e.g. Snellen chart).

Code 99172 is intended for use by Practitioners who provide occupational health services, usually involving the specialties of occupational medicine, internal medicine, family practice and emergency Practitioners.

Code 99172 was created to facilitate reporting of federally mandated visual function screening services for certain workers in an occupational field where optimal vision is crucial and safety standards for vision exist (e.g. firefighter, heavy equipment controller, nuclear power plant operators).
Since a visual function screening would not be provided as an independent/stand alone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99172 will be considered bundled with the service to which it is incident.

The maximum allowable for visual function screening will be $0.00 even when billed alone.

Sources


17. Reimbursement Guidelines for STAT Services
STAT services reported to denote procedures processed as done immediately, as soon as possible, and/or processed with priority.

Reimbursement by BlueCare Tennessee for STAT services will be considered bundled with the service to which it is incident (e.g. specific laboratory, pathology etc. codes) regardless of the location of service.

The maximum allowable fee schedule amount for STAT services is $0.00 even when billed alone.

18. Reimbursement Guidelines for Online Evaluation and Management Services
The American Medical Association established the CPT® codes 99444 and 98969 to report an online evaluation & management service, per encounter, provided by a Physician (99444), or qualified non-Physician health care professional (98969), using the Internet or similar electronic communications network, in response to a patient’s request; established patient.

According to the American Medical Association, an online medical evaluation is a type of Evaluation & Management service provided by a Physician or qualified health care professional, to a patient using Internet resources, in response to the patient’s online inquiry. Reportable services involve the Physician’s personal timely response to the patient’s inquiry and must involve permanent storage (electronic or hardcopy) of the encounter. This service should not be reported for patient contacts (e.g. Telephone calls) considered to be pre-service or post-service work for other E & M or non-E&M services.

A reportable service would encompass the sum of communication (e.g. Related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).

This service is considered bundled with the exception of when the service is approved through an eligible BlueCare Tennessee initiative.

The maximum allowable for evaluation and management services will be $0.00 even if billed alone with the exception of when the service is approved through an eligible BlueCare Tennessee initiative (e.g., Telehealth, Telemedicine, etc.).

This policy applies to services billed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

19. New Patient Replacement Edit for Evaluation and Management Services
For the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a Physician and reported by a specific CPT® code(s).

A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.
An established patient is one who has received professional services from the Physician or another Physician of the same specialty who belongs to the same group practice, within the past three years.

If a new patient evaluation and management code is filed on a patient who has had a new patient evaluation and management code filed by the Physician or another Physician of the same specialty who belongs to the same group within the past three years, clinical editing will replace the new patient evaluation and management code with an established patient evaluation and management code as supported by CPT®.

Evaluation and Management codes are not automatically downcoded with the exception of the above occurrence. If review is applicable and the Evaluation and Management code is not supported by supplemental claim information, Coding and Reimbursement Research will change the billed Evaluation and Management code to the most appropriate code.

CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association website.

This policy applies to services billed on a CMS-1500/ANSI-837P or CMS-1450/ANSI-837I for all BlueCross/BlueCare Tennessee business.

20. Billing Guidelines and Documentation Requirements for CPT® Code 99211

The American Medical Association established the Evaluation and Management CPT® code 99211 to report an office or other outpatient visit for the evaluation & management of an established patient that may not require the presence of a Practitioner. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

According to the American Medical Association, medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history. The medical record facilitates the ability of the Practitioner and other health care professionals to evaluate and plan the patient’s immediate treatment and to monitor his/her health care over time.

There should be documentation in the medical record such as the patient/clinician face-to-face encounter exchanging significant and necessary information. There should be some type of limited physical assessment or patient review. The encounter must be for a problem stated by the patient and not involve solely the performance of tests or services ordered at prior encounters where evaluation and management services were provided. There should be documentation in the medical record of management of the patient’s care via medical decision-making and the medical record should provide evidence that evaluation and management services (consistent with the above) were provided.

Basic Guidelines for billing 99211:

- The patient must be an established patient
- The patient/clinician encounter must be face-to-face
- Some degree of an evaluation and management service must be provided
- Pertinent documentation in the medical record of the encounter is required and documented
- Patient must state a present problem

21. Reimbursement Guidelines for Measurement Reporting Codes

The purpose of measurement codes is to aid performance measurement by easing quality-of-care data collection. These codes generally describe either common components of Evaluation & Management services or test results that are part of a laboratory procedure. Each code is linked to a particular “performance measure set”.

Rev 06/18
BlueCare Tennessee considers measurement-reporting codes bundled to the service to which they are incident. The maximum allowable for measurement reporting codes is $0.00 even when billed alone with the exception of when the service is approved through an eligible BlueCare Tennessee initiative.

Examples of codes classified as measurement reporting codes:
- Category II CPT® codes (i.e., xxxxF codes)
- Other CPT® or HCPCS codes assigned a Status Code "M" (Measurement code, used for reporting purposes only) published on the Medicare Physician Fee Schedule Relative Value File

22. Modifiers Requiring Special Handling

Modifiers are two-digit indicators (alpha or numeric) that, when appended to a procedure code, indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code.

The following guidelines apply to professional claims filed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

**Modifier 22**

**Description**
Unusual Procedural Services

Modifier 22 should be utilized to identify when services provided are greater than what is usually required for the listed procedure. The increment of work represented by affixing modifier 22 should not be frequently encountered when performing the base procedure, nor should it be reportable with another code.

**Guidelines**
Documentation should exist that reflects justification of unusual and extraordinary complex work levels far more extensive than is usually necessary for the listed procedure. Documentation should clearly describe the difficult and complex nature of the procedure and support the difficulty of the case. It would be expected that several complicating factors prove an extremely hard case.

Examples/language which may indicate services may be greater than what would ordinarily be required are:
- Difficulty obtaining desired outcomes- due to anomalies, extenuating circumstances, etc.
- Increased risk due to extenuating circumstances/conditions of patient.
- Extended time to accomplish end results (must be significant and demonstrate why).
- Excessive blood loss/ hemorrhage (must note amount of (estimated) blood loss).
- Trauma extensive enough to complicate procedures- ensure that the complication is not billed with additional procedure codes.
- Pathologies, tumors, anomalies, or malformations that directly interfere with the base procedure, but not reported with other procedures.
- Extensive adhesions- must be more than routine lysis performed to achieve end results and well documented with time involved, etc. and not separately reported.
- Complications, medical emergencies can warrant reporting with modifier 22 when resulting in more work by physician than what would normally be required.
- Clearly more extensive service, based on qualifying factors and/or judgment of reviewer.

Specialty designation of provider type would not automatically qualify service for modifier 22 eligibility.

**Modifier 25**

**Description**
Significant, separately identifiable evaluation and management service by the same Physician on the same day of the procedure or other service.
Under certain circumstances, the physician may need to indicate that a significant and separately identifiable Evaluation and Management (E&M) service was performed beyond the usual pre-procedure, intra-procedure, and post-procedure physician work; or beyond the normal components of another E&M service (e.g., preventive medicine service, anticoagulation management service, osteopathic manipulative treatment, chiropractic manipulative treatment, ophthalmological evaluation service) requiring significant additional work. The E&M service may or may not require a different diagnosis.

**Guidelines**
Modifier 25 will only be recognized as valid to bypass edits when:
- There is documentation of a significant, separately identifiable E&M service which must contain the required number of key elements (history, examination, & medical decision making) for the E&M service reported.
- The E&M service is provided beyond usual preoperative, intraoperative, or postoperative care associated with a procedure performed on the same day.
- A symptom or procedure presents that prompts the E&M service (may not require a separate diagnosis).
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service are billed for the same date of service as an inpatient dialysis service.
- Critical care codes are billed within a global surgical period.
- A Medically Necessary visit is performed on the same day as routine foot care.

Modifier 25 will not be recognized for (including but not limited to the following):
- E&M service that resulted in decision for surgery.
- Ventilation management in addition to E&M service.
- Use on surgical codes.
- Use on same day of minor procedure.
- Use within global surgical period (pre- or post-operative care).

Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Documentation for the evaluation and management service must be able to stand alone.

**Modifier 57**

**Description**
Decision for surgery

Under certain circumstances, an evaluation and management (E&M) service that resulted in the decision to perform the surgery may be identified by adding the modifier 57 to the appropriate E&M service code. When the modifier 57 is used appropriately, the E&M service should be separately reimbursed.

**Guidelines**
Guidelines related to the appropriate reporting of the modifier 57 include, but is not limited to the following:
- Use of modifier 57 may not be valid when the E&M service is associated with a minor surgical procedure. Because the decision to perform a minor procedure is typically done immediately before the service, it is considered a routine preoperative service and therefore not separately reimbursable.
- Modifier 57 may be recognized as valid when used appropriately and there is documentation that the E&M service resulted in the initial decision to perform the service.
- Modifier 57 will not be recognized when the decision to perform the surgery was made in advance of the E&M visit.
- Modifier 57 is not appropriate when reported with non E&M codes.
Provider Administration Manual

- Modifier 57 is not appropriate to report with the E&M service when performed for the preoperative evaluation.
- Use of Modifier 57 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement.

**Modifier 59**

As consistent with the initiatives of the Office of Inspector General (OIG), BlueCare Tennessee reserves the right to evaluate, audit and/or recoup any and all payments resulting from erroneous reporting of the modifier 59. (OIG Workplan, FY 2005)

**Description**

Distinct procedural service: Under certain circumstances, the Physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedure(s)/service(s) that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same Physician.

**Guidelines**

Modifier 59 will only be recognized as valid to bypass edits when:

- Combination of procedure codes represent procedures that would not normally be performed at the same time (e.g. procedure on head and procedure on feet; craniotomy and setting of compound fracture)
- Different session or patient encounter is documented in patient’s medical record
- Surgical procedures performed are not through the same incisional site (Note: doesn’t matter if instrumentation changes if incision or presentation is the same)
- Surgical knee procedures involving multiple compartments of the same knee
- Another modifier is not more appropriate (e.g. Modifier 51)

To determine if Modifier 59 is the most appropriate modifier to use, the following questions must be considered:

1. What is the rationale for the existing edit?
2. Is the edit a National Correct Coding Initiative (NCCI) edit with an indicator ‘0’? If so, there is no appropriate modifier to allow edit bypass.
3. Was the procedure performed in a separate setting, different time, or different encounter?
4. Is there sufficient documentation to support the separateness and distinction of the two procedures?
5. Was the procedure truly separate and/or is it unusual to perform these procedures at the same session?

**National Correct Coding Initiative Superscript Designations - NCCI Indicators**

- Superscript (Indicator) ‘0’ indicates that the edit would never be eligible for bypassing.
- Superscript (Indicator) ‘1’ indicates that there is a valid reason for the code denial but documented special circumstances could validate the edit bypass when the appropriate modifier is used.

Use of Modifier 59 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Modifier 59 should never be appended to an Evaluation & Management service, as this is inappropriate coding convention.

**Modifier KX**

Regulations implementing Section 1557 of the Affordable Care Act prohibit covered entities from denying professional claims for Covered Services ordinarily appropriate for individuals of one sex that are provided to transgender, intersex or ambiguous-gender individuals based on their recorded gender.
Description
The KX modifier is a multipurpose modifier for professional claims and can be used to identify gender-specific services provided to transgender, intersex, or ambiguous-gender individuals. Requirements specified in the medical policy should have been met.

Guidelines
The KX modifier should be billed on the detail line, when appropriate, with procedure code(s) that are gender-specific. Using it also lets us know you performed a service for a Member for whom gender-specific editing may apply, and the service should be allowed to continue with normal processing. All benefit/authorization type requirements still apply.

23. Medically Unlikely Edits (MUEs)
A MUE is a claim line edit that compares the unit of service (UOS) reported for the HCPCS/CPT® code on the claim line to the MUE value for that code. If the UOS on the claim line are less than or equal to the MUE value assigned to the HCPCS/CPT® code, the UOS pass the MUE. If the UOS on the claim line is greater than the MUE value assigned to the HCPCS/CPT® code, the UOS fail the MUE and the entire claim line is denied. That is, no UOS are paid for the code reported on that claim line. For more detailed information regarding MUE guidelines see the following web sites:

https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html


24. TennCare Kids Services
The Division of TennCare requires Providers to refer Members under age 21 for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects and mental illnesses and conditions discovered by the screening services, regardless of whether the required services are covered under the Member’s Managed Care Organization. See Section. XX. TennCare Kids, for additional information and billing guidelines.

25. Injections and Immunizations
a. Reimbursement Guidelines for Vaccines and Toxoids
BlueCare Tennessee shall reimburse Providers for eligible vaccines and toxoids based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there is no published AWP, using one of the following methods:

Method 1
The AWP/WAC based on the National Drug Code (NDC) for the specific product billed.

Method 2
For a single-source product, the AWP/WAC equals the AWP/WAC of the single product. For a multi-source product, the AWP/WAC is equal to the lesser of the median AWP/WAC of all of the generic forms of the product or the lowest brand name product AWP/WAC.

BlueCare Tennessee reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for vaccines and toxoids.

To determine eligibility and reimbursement for a vaccine or toxoid for items billed with a miscellaneous, unlisted, or not otherwise classified CPT® or HCPCS code. BlueCare
Tennessee reserves the right to request the name of the product, National Drug Code (NDC), specific dosage administered and number of units, based on packaging. Reimbursement for vaccines and toxoids will be 100% of AWP or a comparable percentage of WAC.

Reimbursement for the administration of vaccines and toxoids will be made when appropriately billed and submitted on the same claim form with the product administered.

Services included in the State of Tennessee Division of TennCare’s Pharmacy Benefits Manager (PBM) Program are not billable to or reimbursable by the BlueCross BlueShield of Tennessee BlueCare or TennCare Select Networks. Refer to the PBM Program billing guidelines in this Manual.

Note: Refer to the guidelines in the “Vaccines for Children (VFC) Program for BlueCare Members Age 18 and Under” section in this Manual for services eligible for reimbursement under this Program.

b. **Reimbursement and Billing Guidelines for Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs**

**Note:** This policy applies to all eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs filed on a CMS-1500/ANSI-837P claim form.

**Reimbursement Guidelines**

The maximum allowable for eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs for professional and home infusion therapy providers is based on a percentage of Average Sale Price (ASP), Wholesale Acquisition Cost (WAC), or Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the following sources:

**Source A**

ASP as defined and published by Medicare Part B - Tennessee.

BlueCare Tennessee shall update maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs published by Medicare Part B - Tennessee in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

**Note:** BlueCare Tennessee follows the BCBST Policy for Quarterly Reimbursement Changes.

**Source B**

The WAC based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan.

Maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B - Tennessee will be calculated based on a percentage of WAC according to one of the following methods:

**Method 1**

1. The WAC based on the National Drug Code (NDC) for the specific drug billed.

**Method 2**

1. For a single-source drug, the WAC equals the WAC of the single product.
2. For a multi-source drug, the WAC is equal to the lesser of the median WAC of all the generic forms of the drug or the lowest brand name product WAC.
BlueCare Tennessee reserves the right to select the method used to calculate ASP/WAC and the source for ASP/WAC for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B – Tennessee. Examples of sources for WAC include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

To determine eligibility and reimbursement for an injectable drug with an unlisted, miscellaneous, not otherwise classified HCPCS code or for HCPCS codes not published by Medicare Part B – Tennessee, BlueCare Tennessee reserves the right to request the name of the drug, National Drug Code (NDC), specific dosage administered and number of units, based on packaging.

Refer to Provider Contract Agreements for network percentages and specific sources for facility and professional Providers.

Refer to Provider Contract Agreements for network percentages and specific sources for home infusion therapy Providers.

**Billing Guidelines**

**General**

- When billing specific codes for drugs, the number of units billed should be based on the code description rather than the manufacturer’s packaging.
- Place of service should indicate where the medication is administered or instilled into external/implanted pump as defined by CMS rather than where it is dispensed.
- Saline and heparin, utilized for flushing and maintenance of infusion devices, are considered supplies included in professional infusion services and home infusion therapy (HIT) per diems. These are not eligible for separate reimbursement.
- Fluids (i.e., partial-fills) utilized to mix or facilitate administration of the primary medication therapy are considered supplies and are not eligible for separate reimbursement.
- Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one (1) and require submission of drug name, National Drug Code (NDC), and dosage administered. Failure to submit this information will result in delay of reimbursement.
- All supplies dispensed by the Practitioner’s office for home use should be billed with the most appropriate HCPCS supply code(s) (i.e., dressings, elastomeric devices, flushes, etc.) and the appropriate POS code to indicate the location of utilization.

**Compounds**

- Only off-the-shelf medications packaged as manufactured from a pharmaceutical company should be coded utilizing specific HCPCS Level II codes with the exception of some inhalation mixtures having assigned specific codes.
- Refer to Compound Drugs in this Manual section for guidelines on medications compounded from bulk powder or altered from the manufacturer’s packaging.

**Medication Wastage**

- When necessary to discard a portion of a single dose vial (SDV), documentation of time, date, drug name, dosage administered, amount wasted and route of administration in the medical record is expected.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.
- Wastage is not to be billed for medications available in multi-dose vials (MDV) and is not reimbursable.
- The NDC of the SDV requiring wastage should be submitted in Block 24 – Supplemental Information, section of the CMS-1500 or its equivalent. Refer to CMS-1500 Claim Form Block Description in this Manual for additional guidance.
- Block 19 – Reserved For Local Use, section of the CMS-1500 or its electronic equivalent may be utilized if reporting of additional NDCs is required.
Instances of medication wastage from a SDV should be submitted on a single line item with the –JW modifier appended to the appropriate HCPCS Level II code. See general guidelines section for reporting units of drugs with specific codes and for medications billed with Unlisted, Miscellaneous, Non-specific and Not Otherwise Classified (NOC) codes.

The number of units billed for the SDV is inclusive of both the administered plus discarded amounts.

c. Reimbursement Guidelines for Non-Injectable Medications when the Location of Service is the Practitioner's Office

Reimbursement by BlueCare Tennessee for prescription medications other than injectables when the location of service is the Practitioner’s office will not be allowed. Exceptions to this policy include, but are not limited to the prescription drugs addressed under Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

The maximum allowable fee schedule amount for non-injectable medications when the location of service is the Practitioner’s office is $0.00 unless otherwise specified in the Member’s medical benefit plan.

This policy applies to services billed on a CMS-1500/ANSI-837P.

d. Reimbursement Guidelines for Self-Administered Prescription Medications Dispensed and Submitted by a Licensed Pharmacist

Whenever a licensed pharmacist submits a claim for reimbursement for self-administered medications to BlueCare Tennessee, the claim must either be submitted electronically or on a paper claim form through the appropriate pharmacy network. This will ensure that possible duplication of payment can be avoided, that only costs for those prescription medications that are included on the appropriate contract formularies are reimbursed, that those medications that require prior authorization are appropriately reviewed, and that all pertinent pharmacy discounts and copays apply.

If a pharmacy claim is submitted paper to BlueCare Tennessee, that claim will be routed to the appropriate pharmacy network for processing. BlueCare Tennessee will not price prescription drug claims that have been submitted by Licensed Pharmacists.

Self-administered prescription drugs submitted by a licensed pharmacist on a CMS-1500/ANSI-837P or CMS1450/ANSI-837I will not be priced by BlueCare Tennessee as a medical benefit unless otherwise specified by the Member’s medical benefit plan.

e. Reimbursement and Billing Guidelines for Radiopharmaceuticals and Contrast Materials

This policy applies to all eligible drugs filed on a CMS-1500 / ANSI-837P claim form for all BCBST/BlueCare Tennessee business.

The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on the lesser of total covered charges or a percentage of Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the following sources:

Source A
ASP as defined and published by the Centers for Medicare and Medicaid Services (CMS) on the "Medicare Part B Drugs Average Sales Price” file.

Updates to maximum allowables for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the BCBST Quarterly Reimbursement Changes Policy.
Maximum allowables for radiopharmaceuticals and contrast materials not published by CMS will be calculated based on the lesser of total covered charges or a percentage of WAC according to one of the following methods:

**Method 1**
1. The WAC/AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed.

**Or**

**Method 2**
1. For a single-source radiopharmaceutical or contrast material, the WAC equals the WAC of the single product.
2. For a multi-source radiopharmaceutical or contrast material, the WAC is equal to the lesser of the median WAC/AWP of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product WAC/AWP.

BlueCare Tennessee reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP for radiopharmaceuticals and contrast materials without an ASP published by CMS. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BlueCare Tennessee.

In order to determine a reasonable allowable, BlueCare Tennessee reserves the right to request one of the following:

- The manufacturer/supplier’s invoice. When a manufacturer/supplier’s invoice is requested, the name of the patient, name of the specific radiopharmaceutical or contrast material, dosage, number of units and NDC, if available must be provided. If multiple patients are listed on the manufacturer/supplier’s invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BlueCare Tennessee on a CMS-1500/ANSI-837P. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

Refer to **Exhibit A** below for network percentages of AWP/ASP/WAC.

### Exhibit A
**Percentage of Average Wholesale Price (AWP)/Average Sales Price (ASP)/Wholesale Acquisition Cost (WAC) by Network**

<table>
<thead>
<tr>
<th>Network</th>
<th>Percentage of AWP prior to 6/30/2010</th>
<th>Eff. Date</th>
<th>Standard Percentage of ASP</th>
<th>Standard Percentage of WAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare</td>
<td>100%</td>
<td>6/30/2010</td>
<td>120%</td>
<td>110%</td>
</tr>
<tr>
<td>TennCareSelect</td>
<td>100%</td>
<td>6/30/2010</td>
<td>120%</td>
<td>110%</td>
</tr>
</tbody>
</table>

- Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.
- If the radiopharmaceuticals and contrast materials are used in conjunction with a radiological procedure/service that is determined to be ineligible, the radiopharmaceutical and contrast materials will not be reimbursed.
Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.

In order to be considered for reimbursement radiopharmaceuticals and contrast materials must be billed on the same claim as the related radiological procedure/service.

f. **Compound Drugs**

To determine eligibility and reimbursement for compound drugs, BCBST/BlueCare Tennessee reserves the right to request supplemental information.

Eligible compound drugs must be billed with the most appropriate HCPCS Level II code for compound drugs and contain at least one legend drug with a valid National Drug Code (NDC) and billed on a CMS-1500/ANSI-837P claim form. Compounding fees and/or dispensing fees are considered pharmacy benefits rather than medical benefits.

BlueCare Tennessee maximum allowable is $0.00 for the following:

- Non-legend drugs
- Compounding and/or dispensing fees
- Diluents, solvents, or other ingredients utilized to mix, combine, or alter legend drug component(s)

The maximum allowable for compound drugs is determined from individual claim review and may vary by claim based on supplemental information provided with the claim or related claims. Supplemental information includes, but is not limited to:

- The name(s) of the drug component(s), NDC of legend drug component(s), and specific dosage of legend component(s) administered, instilled, inserted, or implanted.

The maximum allowable for eligible compound drugs for professional providers is based on a percentage of Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) based on the Provider Agreement according to one of the following methods:

**Method 1**

1. The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

   Or

**Method 2**

1. For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.

2. For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all of the generic forms of the drug or the lowest brand name product WAC/AWP.

BlueCross reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

g. **Reimbursement Guidelines for Medications Not Requiring a Prescription from a Licensed Physician Regardless of the Location of Service**

Reimbursement by BlueCare Tennessee for medications that do not require a prescription from a licensed Physician regardless of the location of service will be considered non-covered. Exceptions to this policy include those over-the-counter medications that are listed on the BlueCare Formulary.
The maximum allowable for medications that do not require a prescription from a licensed Physician as defined by this policy will be $0.00.

**h. Reimbursement Guidelines for Any Prescription Medications Dispensed by a Provider Other Than a Licensed Pharmacist when the Location of Service is not the Practitioner’s Office**

Reimbursement by BlueCare Tennessee for any prescription medication that has been dispensed by a Provider other than a licensed pharmacist when the location of service is not the Practitioner’s office will not be allowed. This will ensure that only those professionals who are properly trained will administer these services at the contracted rates as stipulated in the Member’s prescription drug benefit plan.

The maximum allowable fee schedule amount for prescription medications dispensed by a Provider other than a licensed pharmacist when the location of service is not the Practitioner’s office is $0.00.

**i. Vaccine for Children (VFC) Program for BlueCare/TennCareSelect Members Age 18 and Under (Does not apply to CoverKids)**

VFC is a federally funded program operated by the State of Tennessee’s Department of Health (DOH). All TennCare enrolled children 18 years of age and under are eligible for the VFC vaccines. These vaccines are available to any Provider who serves eligible Members. See Section. XIV. Preventive Care, for additional information and billing guidelines.

**j. Home Infusion Therapy (HIT) Definitions:**

**Home Infusion Therapy** is the continuous slow introduction of therapeutic agents—analgesics, chemotherapy, prostaglandins, tocolytics, hydration solutions, antibiotics, parenteral nutrition—into the body on an intermittent basis, to achieve practitioner defined beneficial outcomes for the condition being treated in the Member’s place of residence.

- Therapeutic agents instilled into an implanted or ambulatory pump as defined by CMS in the Practitioner’s office are **not** considered HIT.
- Medications delivered to the Practitioner’s office for infusion/instillation in the office setting are **not** billable or reimbursable as HIT.
- Infusion therapy provided in a location other than a Member’s place of residence is **not** billable or reimbursable as HIT.
- Field-based nursing services for drug infusions, PICC insertion, Midline insertion or accessing implanted pumps are considered home health agency/private duty nursing services and are not billable by the home infusion therapy Provider.

**Per Diems** are a payment for each day maintenance is performed or a therapeutic agent is actually infused or instilled into the body, in the Member’s place of residence, as prescribed by the Practitioner.

- A single per diem is reimbursable on the day therapeutic agent(s) is/are instilled into an implanted infusion device in the Member’s place of residence.

**Maintenance** is care of single or multiple lumen infusion catheters or implanted access devices, including dressing changes and flushes necessary to maintain patency between ordered episodes of care with therapeutic agents. (e.g. Monthly flushes of implanted access devices when no active HIT therapy is in progress, IV access flushes and dressing changes during week(s) between chemotherapy episodes or “rounds” of antibiotic therapy while awaiting laboratory results and new orders.)
Maintenance per diem is only separately billable when this maintenance service is the only service provided on that date of service (DOS) and catheter care is actually administered.

Maintenance services provided on the same DOS as HIT with therapeutic agents is included in the per diem for that infusion therapy and not separately billable.

**Multiple Infusion Therapies** are defined as more than one class of service (i.e. pain management, chemotherapy, Epoprostenol, Tocolytic, Hydration, Total Parenteral Nutrition (TPN), anti-infective and miscellaneous) provided concurrently on the same date of service.

**Adjunctive medications** are additional therapeutic agents, administered parenterally, that are included in a concurrent Practitioner ordered HIT regimen (e.g. IVP anti-emetic administered PRN for nausea related to chemotherapy or IV H₂ receptor antagonist administered concurrently with TPN.)

- **Flushes** for catheter maintenance are not considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.) are included in the per diem reimbursement. (See **Per Diems** section below.)

- **Fluids** utilized as diluents or vehicles for administration of other therapeutic agents are not considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies are included in the per diem reimbursement. (See **Per Diems** section below.)

- **Intravenous push (IVP)** is an injection/infusion of a therapeutic agent requiring the continuous presence of the health care professional during administration into a vein or an intravenous injection infusion of a therapeutic agent over 15 minutes or less.
  - Therapeutic medication(s) administered by IVP, dispensed as adjunctive to HIT, may be billed with the appropriate HCPCS code for that ordered medication, but a separate per diem is not billable or reimbursable.
  - Length of infusion is determined based on administration recommendations from recognized sources (e.g. drug handbooks, PDR, and drug package inserts).
  - IVP medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are not billable or reimbursable as part of HIT.

- **Other parenteral medications** are those therapeutic agents administered by intramuscular (IM) injection or subcutaneous (SQ) injection.
  - Other therapeutic parenteral medication(s), dispensed as adjunctive to HIT and not self-administered, may be billed with the appropriate HCPCS code, but a separate per diem is not billable or reimbursable.
  - Other parenteral medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are not billable or reimbursable as part of HIT.

- **Self-administered medications** are defined as Oral, Topical, or self-administered injectable medications, including those indicated as Self-Administered Specialty Pharmacy Products.
  - These are considered a pharmacy benefit and are not billable or reimbursable as HIT.

**Claim Form**

Home Infusion Therapy must be billed on a CMS-1500/ANSI-837-P as follows:

**Block 19 – Reserved for Local Use**

Utilize this section for additional information. (See **Additional Information** section below).

- Additional NDC information when varying packaged products must be utilized to obtain the most economical packaging to achieve the Practitioner ordered dosage for the Member.
Practitioner’s order for therapeutic agent(s) including dosage, route, frequency and duration of therapy.

**Block 24a – From and To Date(s) of Service (DOS)**

Enter the month, day and year for each per diem and therapeutic agent as follows:

- Therapeutic agents billed with a specifically assigned HCPCS code, whose description includes a set amount per unit of the code, may be billed with “span dates” if additional information is submitted to indicate the practitioner order for the **daily dosage amount**. (See example in **Additional Information** section below.)

- Therapeutic agents billed with unlisted, miscellaneous, non-specific, or Not Otherwise Classified (NOC) codes must be billed on a separate line item for each DOS (no span dates) along with additional information including NDC, daily dosage, and drug name. Submitting NOC codes with span dates may result in errors and/or delayed reimbursement. (See example in **Additional Information** section below.)

- Per Diem codes must be billed on a separate line item for each DOS (no span dates). Submitting per diem codes with span dates may result in errors and/or delays in reimbursement.

**Block 24b – Place of Service**

The place of service (POS) should indicate where the therapeutic agent is administered. If the administration is via an implanted or refillable infusion pump as defined by CMS the POS is where the refill was performed.

**Block 24d – Codes, Modifiers and Additional Information (shaded area)**

- Additional information should be submitted in the following format: National Drug Code (NDC) preceded by the N4 qualifier, **dosage administered per day** preceded by appropriate “basis of measurement qualifier” (i.e. GM, ME, ML, etc., as ordered by Practitioner) and name of drug preceded by narrative description modifier, ZZ. (See examples in **Additional Information** section below.)

- All per diems codes and related therapeutic agent codes for the same DOS or span date **must** be billed on the same claim submission. Splitting these services into multiple claims may result in errors and/or delays in reimbursement. (specific guidelines in **Therapeutic agents, Per Diems and Modifiers for Multiple Therapies** follow.)

- More than one medication may be associated with a single per diem (e.g. adjunctive therapeutic agents administered as part of the primary therapy ordered by the physician). Therapeutic agents billed without an associated per diem are considered a pharmacy benefit and should be billed to the Member’s Pharmacy Benefits Manager (PBM).

**Block 24g – Days or Units**

Enter the number of units for each per diem and therapeutic agent as follows:

- Units for therapeutic agents, billed with specific HCPCS codes containing a defined “unit” amount, must be reported in accordance with code definition in effect for the DOS and the Practitioner’s orders.

- Units for therapeutic agents, billed with NOC codes or codes without a defined “unit” amount, must be reported with a unit of (1) per line item / DOS. Reporting multiple units may result in errors and/or delayed reimbursement.

- Units for per diem codes must be reported with a unit of (1) per line item / DOS.
Additional Information

- Additional NDC information related to varying packaged products assigned to the same CPT® or HCPCS code should be indicated in Block 19 (Reserved for Local Use), its electronic equivalent, or submitted as an attachment.

Example for varying packaged products assigned the same CPT® or HCPCS code:

Practitioner order of Octagam 500 mg/kg IV in divided doses over 2 days @ 0.5 mg/kg/min q3wks.

<table>
<thead>
<tr>
<th>19. RESERVED FOR LOCAL USE</th>
<th>Octagam 500 mg/kg IV divided Wt. 150 lbs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N468209084301</td>
<td>Octagam</td>
</tr>
<tr>
<td>12 01 XX 12 02 XX 12 J1568</td>
<td></td>
</tr>
<tr>
<td>12 01 XX 12 01 XX 12 S9379</td>
<td></td>
</tr>
<tr>
<td>12 02 XX 12 02 XX 12 S9379</td>
<td></td>
</tr>
</tbody>
</table>

- The Practitioner’s order for therapeutic agent(s) including dosage, route, frequency and duration should be indicated in Block 19, its electronic equivalent, or submitted as an attachment.

Example for specific HCPCS code billed with span dates:
Practitioner order of Rocephin 1 Gm IV q12h x 5 days is started at 8:00 p.m. on 12/01/XX.

<table>
<thead>
<tr>
<th>19. RESERVED FOR LOCAL USE</th>
<th>Rocephin 1 Gm IV q12h x5d</th>
</tr>
</thead>
<tbody>
<tr>
<td>N4xxxxxxxxxxxxx GM2 ZZRocephin</td>
<td></td>
</tr>
<tr>
<td>12 01 XX 12 06 XX 12 J0696</td>
<td>A XXX xx 40</td>
</tr>
<tr>
<td>12 01 XX 12 01 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
<tr>
<td>12 02 XX 12 02 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
<tr>
<td>12 03 XX 12 03 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
<tr>
<td>12 04 XX 12 04 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
<tr>
<td>12 05 XX 12 05 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
<tr>
<td>12 06 XX 12 06 XX 12 S9501</td>
<td>A XX xx 1</td>
</tr>
</tbody>
</table>
Example for NOC code:
Practitioner order of Abcxyz 400 mg IV q8h x 3 days is started at 4:00 p.m. on 12/01/XX.

<table>
<thead>
<tr>
<th>NDC</th>
<th>Package Code</th>
<th>Quantity</th>
<th>Unit</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>N4xxxxxxxxxx</td>
<td>ME400</td>
<td>ZZAbcxyz</td>
<td></td>
<td>12</td>
<td>01</td>
<td>XX</td>
</tr>
<tr>
<td>N4xxxxxxxxxx</td>
<td>GM1.2</td>
<td>ZZAbcxyz</td>
<td></td>
<td>12</td>
<td>02</td>
<td>XX</td>
</tr>
<tr>
<td>N4xxxxxxxxxx</td>
<td>ME800</td>
<td>ZZAbcxyz</td>
<td></td>
<td>12</td>
<td>03</td>
<td>XX</td>
</tr>
</tbody>
</table>

Per Diem (S9502) should be submitted as indicated in examples above for each of the dates of service therapeutic agent is administered.

**Therapeutic agents**

- Each therapeutic agent must be billed using the most specific CPT®/HCPCS code in effect for the DOS and the NDC. If these codes are billed with span dates, additional information indicating the Practitioner ordered daily dosage amount must be submitted. (See Additional Information section above.)

- Claims for therapeutic agents billed to BlueCare or TennCare Select without following the Deficit Reduction Act (DRA) of 2005 billing guidelines for submitting NDC code and other reporting requirements will be denied. (See Provider-Administered Drug Claims in section F. General Billing Information of this Manual.)

- Therapeutic agents included in the State of Tennessee Division of TennCare’s Pharmacy Benefits Manager (PBM) Program are not billable to or reimbursable by BlueCross BlueShield of Tennessee, BlueCare or TennCare Select Networks. (Refer to section P. Pharmacy Benefits Manager (PBM) Program of this Manual.)

- In the event there is not a specific CPT®/HCPCS code for a therapeutic agent ordered, the most appropriate unlisted code (e.g. J3490, J3590, J9999) in effect for the DOS may be used.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT®/HCPCS code is not available or appropriate. Submitting a NOC code when a more specific code is more appropriate may result in errors and/or delay in reimbursement.

- Therapeutic agents billed with an unlisted miscellaneous, non-specific, and Not Otherwise Classified (NOC) code must be accompanied by additional information as noted in the “Additional Information” section above. Failure to submit this information may result in reimbursement errors and/or delay of reimbursement.

- Reimbursement for therapeutic agent(s) is limited to that amount actually prescribed and administered to the Member.

- HIT Provider is responsible for using the most economical packaging of therapeutic agent(s) to achieve the required dosage for the Member with the least amount of wastage.
BlueCross BlueShield of Tennessee reserves the right to request submission of a copy of the original Practitioner orders for home infusion therapy, if determined necessary for clarification.

**Per Diems**
Maintenance or Home Infusion Therapy per diems **must** be billed using the most appropriate maintenance or "class of service" HCPCS code from one of the following tables:

### MAINTENANCE

Maintenance per diems may only be billed, as a "stand alone service", on days when catheter care is actually administered and these maintenance services are not part of the per diem of another class of service code.

Maintenance per diems are not billable or reimbursable as secondary, tertiary or concurrent therapy.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5498</td>
<td>Single Lumen</td>
<td>Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, per diem</td>
</tr>
<tr>
<td>S5501</td>
<td>Multiple Lumens</td>
<td>Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, per diem</td>
</tr>
<tr>
<td>S5502</td>
<td>Implanted Access Device</td>
<td>Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, per diem</td>
</tr>
</tbody>
</table>

### PAIN MANAGEMENT

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9326</td>
<td>Continuous Infusion</td>
<td>Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, per diem</td>
</tr>
<tr>
<td>S9327</td>
<td>Intermittent Infusion</td>
<td>Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, per diem</td>
</tr>
<tr>
<td>S9328</td>
<td>Implanted Pump Instillation</td>
<td>Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, per diem</td>
</tr>
</tbody>
</table>

### CHEMOTHERAPY

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9330</td>
<td>Continuous Infusion</td>
<td>Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, per diem</td>
</tr>
<tr>
<td>S9331</td>
<td>Intermittent Infusion</td>
<td>Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, per diem</td>
</tr>
</tbody>
</table>
### EPOPROSTENOL

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9347</td>
<td>Uninterrupted Infusion</td>
<td>Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

### TOCOLYTIC

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9349</td>
<td>Infusion Therapy</td>
<td>Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

### HYDRATION

IV fluids utilized as a diluent or vehicles for administration of other therapeutic agents are **not** hydration services. Hydration per diems apply only when services are for the infusion of IV fluids in 1-liter increments solely for the therapeutic treatment of dehydration or other volume related conditions. Only one of the following class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9374</td>
<td>1 Liter</td>
<td>Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9375</td>
<td>2 Liters</td>
<td>Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9376</td>
<td>3 Liters</td>
<td>Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

### TOTAL PARENTERAL NUTRITION

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9379</td>
<td>TPN and / or lipids</td>
<td>Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

### ANTI-INFECTIVE

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9500</td>
<td>Q 24 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9501</td>
<td>Q 12 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>
BlueCare Tennessee
Provider Administration Manual

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9502</td>
<td>Q 8 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9503</td>
<td>Q 6 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9504</td>
<td>Q 4 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

### MISCELLANEOUS

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9379</td>
<td>Infusion Therapy</td>
<td>Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

- Per Diem(s) for class(es) of service not indicated in the above tables **must** be billed with the “miscellaneous” per diem code.

- The reimbursement allowed for the above noted per diem codes includes **all** necessary supplies and equipment, including but not limited to the following. These items should **not** be separately billed.
  - IV Start Kits and sterile site dressing materials (e.g. angio-caths, tape, antimicrobial ointments/pads, alcohol pads, betadine swabs, transparent film dressings, gauze dressings, etc.)
  - IV fluids utilized as vehicles for administration of other therapeutic agents (e.g. keep-vein-open (KVO) solutions, partial-fills, etc.)
  - Sterile saline or water utilized as a diluent for other therapeutic agents.
  - Flush solutions (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.)
  - Tubing, filters, needles and syringes (e.g. pump cassettes with tubing, extension tubing, secondary sets, injection caps, in-line filters, etc.)
  - Disposable drug delivery systems (e.g. elastomeric technology based devices).
  - Daily rental of ambulatory infusion pumps.
  - Anaphylactic agents (e.g. EpiPen, etc.)

- Per Diems for multiple drugs administered in a single class of service (e.g. three antibiotics) will be reimbursed as a single per diem based on the highest administration frequency.

### Modifiers for Multiple Therapies

- The primary class of service per diem must be billed using the most appropriate HCPCS code from the tables above without a modifier.
- The secondary class of service per diem must be billed using the appropriate HCPCS code from the tables above with the "SH" modifier in the 1st modifier field to indicate the second concurrently administered class of service on the same DOS.
- The tertiary or concurrent class of service per diems must be billed using the appropriate HCPCS code from the tables above with the "SJ" modifier in the 1st modifier field to indicate the third or more concurrently administered class of service on the same DOS.

### General Billing Guidelines

- For Members with primary Medicare coverage:
  - Supplies, drugs and equipment utilized in conjunction with HIT must be filed to the
appropriate Medicare carrier prior to filing to BlueCare or TennCare Select for secondary payment.
- Secondary claims for HIT services must be filed with the appropriate Medicare Part B and D electronic remittance advice indicating payment or denial of the services.
- If Part D covers the drug, Providers should submit a $0.00 charge for the drug to BlueCare or TennCare Select. The $0.00 charge indicates that Part D covered the drug and no additional payment is expected.
- Additional information can be found on the CGS Administrators, LLC website at http://www.cgsmedicare.com/.

**k. Diagnostic Medial Branch Block Injections**

The Division of TennCare revised its policy on Medial Block Injections effective Oct. 1, 2013, with the following changes for adults:

- Therapeutic Facet/Medial Block Injections are not covered.
- Diagnostic Medial Branch Block Injections are covered as follows:
  - Limit of four per calendar year
  - Must be performed by a Physician/Practitioner as required by Tennessee Acts 2012, Public Chapter No. 961/SB No. 1935

Claims for Diagnostic Medial Branch Block Injections must be accompanied by supporting documentation, including the Medial Branch Block Injections Certification form to be considered for reimbursement. This form is available online at <http://bluecare.bcbst.com/forms/Provider%20Information/Medial_Branch_Block_Injections_Certification.pdf>.

**l. Trigger Point Injections**

The Division of TennCare revised its policy on Trigger Point Injections effective Oct. 1, 2013, with the following changes for adults:

- Limit of four per muscle group in any period of six (6) consecutive months (counting will start with the first shot on or after October 1).

**m. Epidural Steroid Injections**

The Division of TennCare revised its policy on Epidural Steroid Injections effective Oct. 1, 2013, with the following changes for adults:

- Limit of four per muscle group in any period of six (6) consecutive months (counting will start with the first shot on or after October 1)
- Limits will not apply in conjunction with Labor and Delivery (codes for L&D should be different).

**Note:** Please refer to the TennCare Budget Memo Guidelines located at the end of the General Billing and Reimbursement Information sub-section of this Manual or the Budget Reduction Memo located on our website for more details regarding the above indicated injection benefit limits.

**26. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)**

**Note:** Effective 7/1/18, as part of the Division of TennCare annual budget reductions, for both professional and facility type Providers that supply these services, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Maximum Fee Schedules have changed. As directed by the Division of TennCare, BlueCare Tennessee will utilize the April 2018 DMEPOS Fee Schedule as a maximum/ceiling for reimbursement unless a code has been specifically described in the budget reduction memo as having a different rate (i.e. back brace codes). The fee schedule listing can be found.
To clarify, these rates are intended to be a maximum fee schedule. If any services/codes are paying rates below the listed fee then no changes will be made to those fees. Please view the budget reduction memo located on our website for more information.

a. Durable Medical Equipment (DME) and Medical Supplies

**Durable Medical Equipment (DME)** is any equipment that provides therapeutic benefits or enables the beneficiary to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions and/or illnesses. DME is considered to be equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are items, although durable in nature, which may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes. Source: [http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home](http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home).

**Medical Supplies** are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment that have been ordered by a qualified practitioner in the treatment of a specific medical condition and that are: consumable, non-reusable, disposable, for a specific rather than incidental purpose and generally have no salvageable value.

All supplies dispensed by the Practitioner’s office for home use should be billed with the most appropriate HCPCS supply code(s) (i.e., dressings, elastomeric devices, flushes, etc.) and the appropriate POS code to indicate the location of utilization.

**Claim Form**

Durable medical equipment and medical supplies must be billed on a CMS-1500/ANSI 837P.

**Block 24b - Place of Service**

The place of service (POS) should represent where the item is being used, not where it is dispensed.

**Block 24a - From and To Date(s) of Service**

Enter the month, day and year for each procedure, service or supply. The following items require the use of span dates (i.e. a span of time between the “from and to” dates of service). Failure to use span dates will result in incorrect payment for the following items:

- Enteral Feeding Supply Kits
- Continuous Passive Motion Device
- Enteral Formulae
- Food Thickener
- External Insulin Pump Supplies

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the CMS-1500 claim form for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

**DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.**
Block 24d - Codes and Modifiers

Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) fee schedule are required for correct claim adjudication. In some cases, more than one pricing modifier is required. This document is located on the CGS Administrators, LLC website at http://www.cgsmedicare.com.

Claims billed with inappropriate code and modifier combinations will be returned to provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. E1399) should only be used when a more specific CPT® or HCPCS code is not available or appropriate. Components of the primary equipment should be billed with the most specific CPT® or HCPCS code or the most specific Unlisted, Miscellaneous code.

- Durable medical equipment billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.

**Pricing modifiers** are always appended first in the modifier fields. These will always impact the reimbursement. **Information/descriptive modifiers** are used in the subsequent modifier fields. These are informational or utilized for benefit management by Medicare but do not impact reimbursement.

The following is a partial list of common pricing HCPCS modifiers reported with HCPCS durable medical equipment codes:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AU</td>
<td>Item furnished in conjunction with a urological, ostomy, or tracheostomy supply</td>
</tr>
<tr>
<td>AV</td>
<td>Item furnished in conjunction with a prosthetic device, prosthetic or orthotic</td>
</tr>
<tr>
<td>AW</td>
<td>Item furnished in conjunction with surgical dressing</td>
</tr>
<tr>
<td>KE</td>
<td>Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment</td>
</tr>
<tr>
<td>KF</td>
<td>Item designated by FDA as class III device</td>
</tr>
<tr>
<td>KL</td>
<td>DMEPOS item delivered by mail</td>
</tr>
<tr>
<td>KR</td>
<td>Rental item, billing for partial month</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (use the ‘RR’ modifier when DME is to be rented)</td>
</tr>
<tr>
<td>UE</td>
<td>Used durable medical equipment</td>
</tr>
</tbody>
</table>

**Note:** Labor for DME repairs to Member-owned equipment is to be billed using the most appropriate 5-digit HCPCS Code. A Modifier is not required with the labor codes.

Codes and modifiers must be billed in accordance with the following:

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines which include, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedules
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Coding Bulletins

*This document is located on the CGS Administrators, LLC website at http://www.cgsmedicare.com.
**This document is located on the Noridian Administrative Services, LLC (NAS) website at http://www.dmepdac.com.
Block 24g - Days or Units
For monthly rentals, one unit should be billed for each month the item is rented as the maximum allowable for the rental is for a whole month.

For partial month rentals, one unit should be billed for each month the item is rented. BlueCare Tennessee reserves the right to prorate the maximum allowable to reflect the partial month rental.

For rentals with DME codes and supply kits requiring span dates, one unit should be billed for each day the item is rented or supplied as the maximum allowable is for one day. For enteral, food thickener and external insulin supplies requiring span dates, the units are to be billed in accordance with the unit defined in the code description.

General Billing Guidelines
- The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services, including mileage, are not separately billable.
- Warranties-Supplier must honor all product warranties, expressed and implied, under applicable state law.
- Maintenance and/or service charges for durable medical equipment covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.
- Supplies and accessories related to DME must be billed in accordance with DME MAC for Jurisdiction C guidelines and be on the same claim form as the DME.
- There must be a valid detailed order on file prior to submitting claims for supplies.
- Regular submission of claims for supplies that exceed the usual utilization may prompt a request for medical records to support the need for additional supplies.
- Additional supplies must be requested by a Member or caregiver before being dispensed. Supplies are not to be automatically dispensed on a predetermined regular basis.
- Claim submission for reimbursement consideration should be done on a monthly basis. Only enough supplies to meet the Member’s need for one month should be dispensed at a time.
- The continued need for supplies and the amount on hand must be verified prior to dispensing additional supplies.
- Codes without a published Medicare fee – BlueCross BlueShield of Tennessee reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.
- Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for leased DME will be based on the reimbursement provisions for rented DME.

Note: Ventricular Assist Device (VAD) Supply or Accessory
Effective Dec. 1, 2017, supplemental information will no longer be required when filing medical CMS-1500/ANSI-837P claims with HCPCS Codes Q0508 and Q0509 (Miscellaneous supply or accessory for use with an implanted ventricular assist device) unless specifically requested as indicated below.

The most appropriate codes to use for these dressing supplies are HCPCS codes Q0508 or Q0509. The prepackaged supplies typically contain various items including but not limited to gloves, gauze, tape, anchoring device, bouffant cap, local antiseptic (betadine/dyna dex/chloraprep), and facemask. If there is a specific code for an associated supply or accessory, that specific code should be billed for the item.
When billing for a miscellaneous supply or accessory for use with a VAD, (Q0508 or Q0509), the following documentation should be on file and available upon request:

- Physician’s order for supply/accessory listing frequency and duration of its use
- Invoice for supply/accessory provided
- List of supply/accessory provided whether individually or in a kit
- Office/progress notes for the patient documenting the presence of a LVAD device

Q0508 or Q0509 will be reimbursed as 1 unit per month and shall include all supplies necessary to treat members VAD dressing changes.

**Aerosol Therapy**
- Equipment used in conjunction with aerosol therapy must be billed by a durable medical equipment provider.
- Supplies used in conjunction with aerosol therapy must be billed by a durable medical equipment provider or medical supplier.
- Inhalation medication used in conjunction with aerosol therapy must be billed through the State of Tennessee Division of TennCare’s Pharmacy Benefits Manager (PBM).
- Items included in the State of Tennessee Division of TennCare’s Pharmacy Benefits Manager (PBM) program are not billable to or reimbursable by the BlueCross BlueShield of Tennessee BlueCare or TennCare Select Networks. Refer to the PBM program billing guidelines at the end of Sec V. in this Manual.

**Enteral Therapy**
- Equipment used with enteral therapy must be billed by a durable medical equipment provider.
- Supply kits, pumps and formulae used with enteral therapy must be billed by a durable medical equipment provider or medical supplier. These items must be billed with the most appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be billed as follows:
  - **Supply Kits** – The appropriate “B” HCPCS code should be billed with span dates using one unit for each day a kit is used. These are disposable supply items and no modifier is required to indicate a purchase. A span date indicates the time period services were provider; i.e., 01012004 to 01152004. Because of the use of span dates, a separate line item is not required for each day.
  - **Pump** (if used) – Pumps are considered as monthly rentals. The “from” and “to” dates on the claim should indicate the month, day and year for the rental; i.e., 01012004 to 01012004. One unit should be used for each month the pump is rented.
  - **Formulae** – Span dates should be used to indicate the period formulae were provided. Per 2004 HCPCS coding guidelines, formulae are billed with one unit for 100 calories. If formulae has not been assigned a specific HCPCS code by Pricing, Data Analysis and Coding Contractor (PDAC), bill formulae using B9998 with one unit for each 100 calories. BlueCare Tennessee requires the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement.
  - **Food Thickener** – Span dates should be used to indicate the period thickener was provided. Per 2004 HCPCS coding guidelines, food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned by Pricing, Data Analysis and Coding Contractor (PDAC). Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box, or container. BlueCare Tennessee requires the complete brand name and NDC for thickener billed with this miscellaneous code to determine appropriate reimbursement.
name, volume of container supplied, manufacturer’s name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

**Note:** Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding. (Oral enteral therapy is not covered under CoverKids.)

**DME Repairs, Adjustments, and Replacements**
- If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the rental for the equipment and are not separately billable.
- Reimbursement for reasonable and necessary parts and labor to Member-owned equipment which are not covered under any manufacturer or supplier warranty may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the Modifier 1 field. Labor should be billed using the most appropriate HCPCS Code. A Modifier will not be required with Labor codes.
- Billable parts and labor must be billed on the same claim form.
- Mileage is not separately reimbursed or billable.
- Repairs to Member owned durable medical equipment are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess.
- Temporary replacement for patient owned equipment while being repaired billed as K0462 require a description and procedure code of the Member owned equipment being repaired.
- Thirty (30) days is allowed for rental of loaner equipment when Member owned equipment is being repaired.

**Guidelines for Wheelchairs**
- All accessories related to the purchase of a wheelchair base must be billed on the same claim form as the wheelchair base itself.
- If multiple accessories are provided using the miscellaneous code K0108, each should be billed on a separate claim line.
- Code E1028 is appropriate for swingaway, removable or retractable hardware (e.g. joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g. hardware for seat, back or tray).
- A separate claim line is required for each item billed with code E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.
- Bilateral accessories should be submitted with the right and left modifiers in the secondary modifier fields.

For information on items appropriately billed with E1028, refer to the DME Product Classification List located on the Noridian Administrative Services, LLC (NAS) website at [http://www.dmepdac.com](http://www.dmepdac.com).

**Reimbursement Guidelines for Durable Medical Equipment (DME) Purchase and Rentals**
This policy applies to durable medical equipment purchases and rentals billed on a CMS-1500/ANSI 837P for all BCBST/BlueCare Tennessee lines of business effective 4/1/09, and after.

The maximum allowable for durable medical equipment classified as Capped Rental, Inexpensive/Routinely Purchased, TENS, and enteral nutrition infusion pumps (i.e. purchases and rentals) will be the lesser of covered charges or the contracted network percentage of the DME MAC for Jurisdiction C DMEPOS Fee Schedule for Tennessee.
Durable medical equipment will be considered purchased after the equipment has been rented for a period of 10 months.

The published Medicare fees for durable medical equipment classified as Capped Rentals are based on a thirteen (13)-month rental period where the Medicare allowable for the first 3 months is at 100% and the Medicare allowable for the remaining ten (10) months is at 75%. Since BlueCare Tennessee considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as Capped Rentals (except Power-Driven Wheelchairs) will be adjusted as follows:

\[
P_{\text{purchase}} = P_{\text{Medicare}} \times 3 \times 100\% + P_{\text{Medicare}} \times 10 \times 75\%
\]

BlueCare Tennessee Purchase Allowable = Medicare Purchase Fee x Contracted Network %
BlueCare Tennessee Rental Allowable = BlueCross BlueShield of Tennessee Purchase Allowable/ten (10) months

**Capped Rental for Power Driven Wheelchairs:**

\[
P_{\text{purchase}} = P_{\text{Medicare}} \times 3 \times 150\% + P_{\text{Medicare}} \times 10 \times 60\%
\]

BlueCare Tennessee Purchase Allowable = Medicare Purchase Fee x Contracted Network %
BlueCare Tennessee Rental Allowable = BlueCross BlueShield of Tennessee Purchase Allowable/ten (10) months

If the Member changes to different but similar equipment (e.g. from a non-heated humidifier to a heated humidifier) when the equipment is medically needed (i.e. the member's medical needs have substantially changed and the new equipment is necessary), a new ten (10)-month rental period begins with the new equipment. Otherwise, BlueCare Tennessee will reimburse the least expensive piece of equipment (continuing to count against the current ten (10)-month period). If the ten (10)-month rental period has already expired, then no additional rental payments can be made.

Reimbursement for supplies used in conjunction with durable medical equipment will be determined by the DME MAC for Jurisdiction C guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item.

All maximum allowables for rentals are monthly rates unless specified otherwise on the Maximum Allowable Detail Report.

BlueCare Tennessee reserves the right to pro-rate the maximum allowable for partial month rentals.

Providers are contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level. DME Providers must follow the DME Quality Standards set forth by CMS, which include:

- Assistive Technology certification for custom wheelchair suppliers;
- Certified Respiratory Therapists on staff when respiratory equipment supplied; and
- Accreditation as verified by the BCBST/BlueCare Tennessee Credentialing Department.

**Note:** Effective with dates of service July 1, 2013 and after, BlueCare adopted Medicare’s policy for Implementation of Standards for Coverage of TENS and CLBP that no longer allows coverage of TENS Unit for Chronic Low Back Pain.
b. **Oxygen, Oxygen Contents, Oxygen Supplies**

This policy applies to Oxygen systems, supplies, and contents billed on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee lines of business effective 4/1/09, and after.

BlueCross/BlueCare Tennessee reserves the right to pay the rental of oxygen systems to include oxygen contents, oxygen supplies and accessories for as long as the patient’s need continues.

Reimbursement for rental of oxygen, contents, supplies and accessories will be based on the lesser of covered charges or the BCBST/BCT maximum allowable fee schedule allowance for the service.

Reimbursement for rental of oxygen systems, contents, supplies and accessories for all BlueCross networks including BlueCare and Corporate Medicare will be limited to services eligible for separate reimbursement per the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C Durable Medical Equipment, Prosthetics, Orthotics and Supplies Supplier Manual (DMEPOS) in effect for date of service prior to 1/1/2006.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up education, and on-going assistance with the item.

All maximum allowables for reimbursement rentals are monthly rates unless specified otherwise.

To be considered for reimbursement, oxygen systems, contents, supplies and accessories for eligible services must be billed in accordance with standard coding and billing guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

c. **Reimbursement Guidelines for Home Pulse Oximetry**

**Spot Home Pulse Oximetry**

A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide adjunctive information for the clinician. It is no different than any other routine vital sign (e.g. blood pressure) obtained as part of a general patient assessment.

Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check.

When used as a spot oxygen saturation check, home pulse oximetry should not be billed separately from the rental of oxygen equipment or the home health visit.

**Continuous Home Pulse Oximetry**

Reimbursement for Medically Appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a CMS-1500/ANSI-837P for all BlueCross/BlueCare Tennessee business.

d. **Prosthetics and Orthotics**

**Qualified Providers**

Providers billing prosthetic and orthotic equipment must meet the credentialing requirements for Orthotic/Prosthetic Supplier outlined in Section XVII, Credentialing in this Manual.

**Claim Form**

Prosthetics and orthotics must be billed on a CMS-1500/ANSI 837P.
Block 24b - Place of Service
The place of service (POS) should represent where the item is being used, not where it is dispensed.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each procedure, service or supply.

Block 24d - Codes and Modifiers
Prosthetics and orthotics must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

Claims billed with inappropriate code and modifier combinations will be returned to Provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. L0999, L1499, L2999, L3649, L3999, L5999, L7499, L8039, L8499, L8699, L9900) should only be used when a more specific CPT® or HCPCS code is not available or appropriate.
- Failure to submit the most specific CPT® or HCPCS code or the omission of modifiers will result in denial and return of claim to provider for most appropriate coding.
- Prosthetics or orthotics billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.
- Codes without a published Medicare fee - BlueCare Tennessee reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.

To facilitate claim adjudication claims for bilateral orthotics coded with a single code and provided on the same DOS are to be submitted as a single claim line using the LTRT modifiers and 2 units of service. Codes and modifiers must be billed in accordance with the following:

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines which includes, but are not limited to the following:
  - DMEMOS Supplier Manual and Revisions
  - DME MAC for Jurisdiction C Insider Fee Schedules
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Coding Bulletins
*This document is located on the CGS Administrators, LLC website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com).
**This document is located on the Noridian administrative Services, LLC (NAS) website at [http://www.dmpdac.com](http://www.dmpdac.com).

- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law. Maintenance and/or service charges for prosthetics and orthotics covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.

- Mileage is not separately reimbursed or billable.

**Prosthetics**

- Repairs, Adjustments, and Replacements
  - An adjustment is any modification to the prosthesis due to change in the patient's condition or to improve the function of the prosthesis.
  - A repair is a restoration of the prosthesis to correct problems due to wear or damage.
  - A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

- The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable:
  - Evaluation of the residual limb and gait
  - Fitting of the prosthesis
  - Cost of base component parts and labor contained in HCPCS base codes
  - Repairs due to normal wear or tear within 90 days of delivery
• Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities

➢ Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis is not separately billable.

➢ Repairs to prosthesis are billable when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payment can be made for the amount of the excess. Maintenance, which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist, is billable as a repair.

➢ Reimbursement for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code. Labor should be billed using the most appropriate HCPCS code (e.g. L7500, L7520).

Billable parts and labor must be billed on the same claim form.

Orthotics

➢ Evaluation of the patient, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable. There is no separate payment for these services.

➢ Repairs to an orthotic due to wear or to accidental damage are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.

➢ Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the Member's condition, irreparable wear, or irreparable accidental damage is billable if the device is still Medically Necessary. The reason for the replacement must be documented in the supplier's record.

➢ The allowance for the labor involved in replacing an orthotic component that is coded with a specific L code is included in the allowance for that component and is not separately billable.

➢ The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous code L4210 is separately billable in addition to the allowance for that component. Billable orthotic components and labor must be billed on the same claim form.

e. Reimbursement and Billing Guidelines for Codes Classified as Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable

Codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable may require submission of the manufacturer name, product name, product number, and quantity.

The maximum allowable for these services will be based on the lesser of covered charges or the following percentages of the manufacturer’s published list price as defined by BlueCare Tennessee:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Medical Supplies</td>
</tr>
<tr>
<td>100%</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>100%</td>
<td>Orthotics</td>
</tr>
<tr>
<td>100%</td>
<td>Prosthetics</td>
</tr>
</tbody>
</table>
Sources used by BlueCare Tennessee to determine the manufacturer's published list price include, but are not limited to:

- Information provided to BlueCare Tennessee by manufacturer (e.g. product catalogs, product price listings, direct inquiries to manufacturer, manufacturer order forms and Provider-submitted invoices with list price).

In the event BlueCare Tennessee is unable to determine the manufacturer's published list price using one of the aforementioned sources, BlueCare Tennessee reserves the right to request submission of an unaltered manufacturer/supplier's invoice indicating the product acquisition cost after all discounts and rebates. The maximum allowable for these items will be the lesser of covered charges or 120% of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to all BCBST/BlueCare Tennessee business for:

- durable medical equipment, medical supplies, orthotics, and prosthetics billed on the CMS-1500/ANSI-837P; and
- medical supplies on the BlueCare Tennessee Home Health Non-routine Supply List billed by a home health agency on the CMS-1450/ANSI-837I.

Reimbursement for codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable is subject to the Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction C (DME MAC), BlueCross/BlueCare Tennessee reimbursement guidelines and BCBST/BlueCare Tennessee billing guidelines.

27. Transportation

a. Emergency Ambulance Services

BlueCare Tennessee recognizes Emergency Transportation as any transport that is dispatched through a 911 call. Reimbursement is provided based on the HCPCS code indicating that it was an emergency response rather than the level of care assessed at the scene. This is not a contracted service, but is a benefit for BlueCare/TennCareSelect Members as long as an actual transport was provided and the claim is billed appropriately. Emergency claims are billed directly to BlueCare Tennessee by the Emergency Medical Service (EMS) Provider.

- **Emergency Ambulance Billing Requirements:**
  - Emergency ambulance services can be billed directly to BlueCare Tennessee on a CMS-1500 or CMS-1450 paper claim form or electronically in the ANSI-837P or 837I format.
  - Emergency ambulance services must be billed using the appropriate HCPCS Codes. When possible avoid the use of A0999 - Unspecified Ambulance Service.
  - HCPCS transportation modifier codes are required for each line item billed. For valid transportation modifiers providers should reference the HCPCS Coding Manual in effect for the date of service being submitted. Emergency ambulance services submitted without the appropriate modifier code will be non-covered or returned to the Provider.
  - Air ambulance claims (A0430/A0431) will be reimbursed as an all-inclusive charge per date of service.

- **Additional professional Air Ambulance billing requirements –**
  - For claims submitted on the CMS-1500 claim form the Pick-up Location Zip Code should be submitted in Block 23 Prior Authorization Number. Multiple Zip Codes should not be submitted in this block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct ZIP Code is five numeric digits; if a nine-digit ZIP Code is submitted the last four digits are ignored.
  - For electronic claims the Ambulance Pick-up Location information must be submitted as required by (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1) guidelines.
  - If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.
CMS-1500 Claim Form Field Requirements:
Block 23 Authorization# and/or Dispatch# or for Air Ambulance services Pick-up Location Zip Code
Block 24b Place of Service (41, 42)
Block 24d Procedure Code and HCPCS Codes Modifiers
Block 32 Member Pick-up Location
Block 33a NPI

b. Non-Emergency Medical Transportation (NEMT) (See Attachment I of this Manual for additional non-emergency medical transportation information.) (Does not apply to CoverKids)

Non-emergency medical transportation services are billed directly to Southeastrans. NEMT Providers should complete the Trip Reimbursement Form (Driver Log) and submit to Southeastrans. Southeastrans will convert the Trip Reimbursement Form to the correct HCPCS codes (A-codes) and submit the information to BlueCare/TennCareSelect via encounter data reporting. Mail non-emergency transportation Trip Reimbursement Forms to:

Southeastrans, Inc.
4751 Best Road, Suite 300
Atlanta, GA 30337

C. Billing Guidelines for Ambulance Services
Claims filed to BlueCare and/or TennCareSelect for ambulance services are to be filed with the appropriate origin and destination modifiers as outlined by national standards.

Note: Per electronic billing requirements related to the ANSI 5010 transition, ambulance claims filed for BlueCare or TennCareSelect Members must contain a “CR1” segment or claims will be rejected. This segment is used to supply information related to the ambulance service and applies to electronically filed claims only. Additional information may be found at: <http://www.bcbst.com/providers/ecomm/CompanionImplementationGuides/Supplemental_BlueCareTennCareSelect_Edits.pdf>.

28. Newborns
(Does not apply to CoverKids)
TennCare requires each individual have a unique identification number. Parents are required to contact the local Department of Human Resources to request a temporary ID number on newborns. Claims can be filed under the mother’s unique identification number for thirty (30) calendar days after the birth of the baby. If the baby has been issued a temporary or permanent ID number, claims must be filed using the baby’s ID number. After the initial thirty (30) days, if the newborn’s charges are still filed using the mother’s ID number they will be denied.

29. Medication Therapy Management Pilot Program
(Does not apply to CoverKids)
Medication therapy management (MTM) program is defined as distinct service or group of services which optimizes therapeutic outcomes for individual TennCare Members. MTM services include medication reviews, pharmacotherapy consult, anticoagulation management, immunizations, health and wellness programs and many other clinical services.

Pharmacists provide MTM services to help TennCare Members get the best benefits from their medications by managing drug therapy and by identifying, preventing, and resolving medication-related problems.

The pilot authorizes qualified Tennessee-licensed pharmacists to provide MTM services to eligible TennCare Members under a collaborative practice agreement (CPA) with TennCare Patient Centered Medical Homes (PCMH) and Health Link (HL) organizations.

Medication Therapy Management (MTM) Reimbursement Guidelines: The Case Rates for MTM Covered Services are described below:
### Service Description

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Modifier Code</th>
<th>Case Rate</th>
<th>Payment Limits</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Targeted Disease States (Juvenile Asthma or Diabetes)</td>
<td>U1</td>
<td>$15.00</td>
<td>2 Months</td>
<td>1 unit for each case rate</td>
</tr>
<tr>
<td>Medium-High Risk</td>
<td>U2</td>
<td>$15.00</td>
<td>3 Months</td>
<td>1 unit for each case rate</td>
</tr>
<tr>
<td>Critical, High Risk</td>
<td>U3</td>
<td>$25.00</td>
<td>6 Months</td>
<td>1 unit for each case rate</td>
</tr>
<tr>
<td>Exceptions (Requires appropriate approval)</td>
<td>U4</td>
<td>Rate based on level of care modifier</td>
<td>Limit based on appropriate approval</td>
<td>1 unit for each case rate</td>
</tr>
</tbody>
</table>

CPT® codes 99605, 99606, and 99607 should be submitted for face-to-face visits. Pharmacist will bill the appropriate CPT® code (99605 for a new patient or 99606 for an established patient) in conjunction with the service modifier to receive appropriate case rate reimbursement. To track and report time, if a visit lasts more than 15 minutes, pharmacist will also submit 99607 with an additional unit for each 15 minute increment. Please note, CPT® 99607 code is for informational purposes only and does not impact the claims payment.

MTM services provided by Indirect (telephonic) must be submitted using codes 98966, 98967, or 98968. These CPT® Codes must be billed with place of service 02.

Pharmacist must complete and upload an MTM exception (ME) form to the Care Coordination Tool (CCT) and send one to BlueCare Tennessee for any service limit exceptions. Claims submitted beyond the risk-based maximum limit as described in this section may be subject to recoupment unless a MTM exception (ME) form is received. BlueCare Tennessee will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by TennCare. Upon billing, the U4 modifier is to be addressed on the claim as the second modifier.

Only one Case Rate payment will be made per member per month based on the pharmacist who submits the first claim for the billing month. If Member switches pharmacist in the middle of treatment the limit will follow the Member (i.e. High Risk level member had 2 visits with first pharmacist. The new pharmacist only has 4 visits remaining). Members who change risk categories (i.e. from medium high to critical) are eligible for service limits equal to the higher risk service payment limit.

For more information about the pilot and the credentialing/contracting requirements please refer to the Division of TennCare’s website at https://www.tn.gov/tenncare/providers/pharmacy/medication-therapy-management-pilot-program.html.

### J. Staff Supervision – Requirements for Delegated Services

This policy defines BlueCross BlueShield of Tennessee/BlueCare Tennessee requirements for supervision by eligible Physicians and Chiropractors of their associates and assistants. Supervision by itself does not create eligibility for the services of associates and assistants. Such Practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement. The policy also describes requirements for billing delegated services. To the extent that state or federal law or regulation exceeds these internal requirements, these laws or regulations will control.

Licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Doctor of Podiatric Medicine (DPM), Licensed Professional Counselor (LPC), Licensed Clinical Social Worker
(LCSW), and Licensed Pharmacist are examples of autonomous Providers. Their services do not require the supervision of another profession. These Practitioners should bill their services under their own provider number, NPI, or the provider number, NPI of their facility. (Refer to clarification of term “autonomous” under Clarification of terms used within this policy.)

Provider categories/billing and supervision requirements follow:

- **Licensed Providers Requiring Supervision by Retrospective Review**
  
  Supervision by Retrospective Review is defined as supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual’s medical record (e.g., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (e.g., facility, office) during the time that a delegated service is performed.

  Licensed Providers requiring supervision by Retrospective Review include Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Licensed Resident Physician, Nurse Practitioner, and Physician Assistant.

  Supervising Physicians or Chiropractors are required to perform a review of the services they delegate to this category of Practitioner. Providers in this category are required to complete the full credentialing process with BlueCare, and they are required to bill directly under their own BlueCare Tennessee provider billing number or the provider number of their group or facility. This does not apply to Providers rendering services at health departments or licensed residents when performing services that are a part of their residency program.

  **Supervising Physicians and Chiropractors must:**
  - Annually review and document the licensure or certification of any office staff or employee to whom they delegate medical services.
  - Review the patient records and certify by signed notation that evaluations and treatment plans are appropriate, as prescribed by law.
  - Only delegate services that are within the scope of the delegated Practitioner's license.

  **Specific Billing Requirements:**
  
  Block 31 Practitioner rendering the service
  Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
  33a NPI # of the billing Provider.
  33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

- **Licensed Physicians Requiring Minimal Supervision**
  
  Minimal Supervision requires that the supervising/treating Physician evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

  However, effective July 1, 2007, Senate Bill No. 1144 and House Bill No. 964 allows for direct patient access to licensed physical therapists without an oral or written referral from a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy under the conditions set forth in T.C.A. Section 63-13-303.

  Licensed Physicians requiring Minimal Supervision include Certified Athletic Trainer, Certified Audiologist, Certified Occupational Therapist, Chiropractic Radiology Technician, Licensed Physical Therapist, Licensed Physical Therapy Assistant, Licensed Practical Nurse, Licensed Psychological Examiner, Medical Laboratory Technologist, Orthopedic Physician Assistant, Radiologic Technician,
Registered Dietitian/Registered Nutritionist, Registered Nurse, Registered Respiratory Therapist, Speech and Language Pathologist. Some Practitioners within these health care fields may be eligible for a BlueCare Tennessee provider ID number.

Supervising Physicians, Chiropractors, or Psychologists are required to supervise the provision of delegated services for this category of Providers. If the actual provider of the service needs the direction or supervision of a Chiropractor, Physician or Psychologist to legally perform a service and is ineligible to bill under their own number, then the Chiropractor, Physician or Psychologist will be allowed to bill those services under their name, provider number and/or NPI. The actual provider of service must also be listed on the billing form (i.e., in Block 31 of the CMS-1500 claim form).

**Supervising Physicians, Chiropractors and Psychologists must:**

- Annually review and document the licensure or certification of any office staff or employees to whom they delegate medical services;
- Only delegate services that are within the scope of the Practitioner’s certification or license as determined by law. Such services should not require the exercise of independent professional judgment;
- Include the following documentation: 1) an evaluation of the patient prior to delegating or ordering any services, 2) a specific order for the service to be delegated, and 3) notation of the results obtained from the service ordered.
- Use treatment protocols from nationally recognized professional sources and have them available on-site for review by BlueCare Tennessee.

**Specific Billing Requirements:**

Block 31 Practitioner rendering the service
Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
   33a NPI # of the billing Provider.
   33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

**Certified Providers Requiring Direct and Close Supervision**

Direct and Close Supervision requires that the supervising Physician have, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (e.g., facility, office) and readily available during the time that a delegated service is rendered.

(Note: See Extenuating Circumstances.) Being available via telephone does not constitute direct and close supervision.

Certified Providers requiring Direct and Close Supervision include Certified Chiropractic Therapy Assistant, Certified Medical Assistant, Certified Nursing Assistant, Certified Occupational Therapy Assistant, Certified Podiatric Assistant, Medical Laboratory Technician, and Speech Language Pathology Assistant. These healthcare practitioners are not eligible for a BlueCross BlueShield of Tennessee/BlueCare Tennessee Provider ID number.

**Supervising Physicians, Chiropractors and Therapists must:**

- Annually review and document certification of any office staff or employees to whom they delegate medical services.
- Only delegate services in which the supervising Practitioner materially participates. “Materially participate” means the supervising Practitioner must evaluate the patient immediately prior to the service, prepare a detailed written order, and perform a final evaluation of the patient and the service performed prior to the patient leaving the facility. The final evaluation should ensure that the service was delivered appropriately and was
clinically effective. The supervising Practitioner must be on-site and available at all times. Documentation in the patient medical record must reflect that these steps occurred.

- Follow required treatment protocols from nationally recognized sources. Protocols must be kept on-site and be made available for review by BlueCare Tennessee.
- Only delegate services that do not require clinical judgment or could not be construed as a service requiring the expertise of Practitioners in categories 1 & 2.

**Extenuating Circumstances**

Under extenuating circumstances (e.g., network inadequacy in rural areas) a licensed/certified therapy assistant may render services through a home health provider in the home health setting under the general supervision of a licensed therapist. Under these conditions, a licensed therapist must evaluate the patient, develop a treatment plan, and implement the plan. General supervision requires initial direction and periodic re-evaluation by the registered therapists; however, the supervisor does not have to be physically present or on the premises.

**Specific Billing Requirements:**

- Block 31 Practitioner rendering the service
- Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
- 33a NPI # of the billing Provider.
- 33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

**Clarification of terms used within this policy:**

**Autonomous Providers** – Providers who by their state license are qualified to diagnose and initiate treatment independently. For example, a Doctor of Chiropractic (DC) is licensed to diagnose and initiate chiropractic treatment without an order to treat from another profession. A DC is an autonomous Provider and as such, does not require supervision or orders from another profession.

**Supervision by retrospective review** – Supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual’s medical record (i.e., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (i.e., facility, office) during the time that a delegated service is performed.

**Minimal supervision** – Requires that the supervising/treating Practitioner evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

**Direct and close supervision** – Requires that the supervising Practitioner has, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (i.e., facility, office) and readily available during the time that a delegated service is rendered. (Note: Extenuating circumstances above.) Being available via telephone does not constitute direct and close supervision.

**K. Locum Tenens Policy**

A “locum tenens” is a temporary Practitioner who fills in for a Practitioner on a short-term basis. A Practitioner who is to be a permanent member of a practice or who performs services for over sixty (60) days does not meet the definitions of a “locum tenens” and must initiate contracting and credentialing with BlueCross BlueShield of Tennessee/BlueCare Tennessee. Any Practitioner that has been denied
credentials by BCBST and has not successfully appealed that denial can not serve as a locum tenens and treat BCBST/BlueCare Tennessee Members as an in-network Provider or bill under an in-network Provider’s ID number.

The substitute Practitioner generally does not have a practice of his/her own and moves from area to area as needed. The regular practitioner generally pays the substitute practitioner or an agency a fixed amount per diem, giving the substitute practitioner the status of independent contractor rather than an employee.

A BlueCare Tennessee Participating Practitioner may submit a claim for a Member’s Covered Services (including emergency visits and related services) of a “locum tenens” Practitioner* who has a valid Medicaid ID number, is not an employee, and whose services for Members of the regular Practitioner are not restricted to the regular Practitioner’s office, if:

- The Member has arranged or seeks to receive services from the regular Practitioner;
- The regular Practitioner is unavailable to provide the visit services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.;
- The regular Practitioner has left a group practice and the group has engaged a “locum tenens” Practitioner as a temporary replacement until a permanent replacement Practitioner is obtained. In this case, group must select a member of the group as an oversight Practitioner.
- The regular Practitioner, or group practice acting on his behalf, sends a non-participating form and letter to the appropriate BlueCare Tennessee Provider Network mailbox, PNS_GM@BCBST.com stating the reason for “locum tenens”. The letter should state the date the services will begin and the estimated end date. To expedite your request, add “Locum Tenens” in the subject line of your e-mail;
- The regular Practitioner, or group practice acting on his behalf, has ascertained that the “locum tenens” is qualified by training and experience to temporarily maintain the regular Practitioners’ practice;
- The regular Practitioner pays the “locum tenens” for his/her services on a per diem or similar fee-for-time basis; Compensation paid by a group to the “locum tenens” Practitioner is considered paid by the regular Practitioner for purposes of this policy.
- The services are not provided over a continuous period of longer than sixty (60) days. The regular Practitioner, or group practice acting on his behalf, must keep on file a record of each service provided by the substitute Practitioner and make the records available to BlueCare Tennessee upon request;
- CMS-1500 claims should be submitted with BlueCare Tennessee Participating Practitioner’s name and individual provider number and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider. In case of regular Practitioner who has left group practice, claims should be submitted with BlueCare Tennessee Participating Oversight Practitioner name and individual provider number and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider.

* Locum Tenens must have a valid Medicaid ID number to refer, order, or render services.

L. CMS-1450 Facility Claim Form

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Facility claims submitted to BlueCare Tennessee must be filed on the CMS-1450 (UB-04) paper claim form or its electronic equivalent.

BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

The UB-04 contains a number of improvements and enhancements over the UB-92 paper claim form that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form is able to accommodate the reporting of the National Provider
Identifier (NPI) Number. The NPI is a single provider identifier, replacing the different provider identifiers
health care systems used for each health plan with which they do business. The NPI Identifier, which
implements a requirement of Health Insurance Portability and Accountability Act of 1996 (HIPAA), must
be used by all HIPAA covered entities, which are health plans, healthcare clearinghouses, and
healthcare Providers.

A sample copy and field descriptions of the UB-04 claim form follow:

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<th>Field</th>
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Rev 03/07

V-100
CMS-1450 (UB-04) Form Locators and Field Description:

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<th>Provider Name, Address, Telephone Number***</th>
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<td>Form Locator 6</td>
<td>Statement Covers Period***</td>
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<td>Form Locator 8</td>
<td>8a&gt;Patient Name-ID 8b&gt;Patient Name***</td>
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<td>Form Locator 9</td>
<td>9a&gt;Patient Address-Street 9b&gt;Patient Address-Other 9b&gt;Patient Address-City 9c&gt;Patient Address-State 9d&gt;Patient Address-Zip 9e&gt;Patient Address-Country Code***</td>
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<td>Patient Sex***</td>
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<td>Form Locator 12</td>
<td>Admission Date*** (Inpatient)</td>
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<td>Admission Hour*** (except for Bill Type 02X)</td>
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<td>Form Locator 14</td>
<td>Type of Admission/Visit***</td>
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<td>Form Locator 15</td>
<td>Source of Admission***</td>
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<td>Form Locator 16</td>
<td>Discharge Hour*** (final inpatient claim only)</td>
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<td>Patient Discharge Status***</td>
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<td>Form Locator 31</td>
<td>a-b Occurrence Code/Date</td>
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<td>Form Locator 32-34</td>
<td>a-b Occurrence Codes and Dates</td>
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<td>a-b Occurrence Span Code/From/Through</td>
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<td>a-b Occurrence Span Code/From/Through</td>
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<td>1-5 Responsible Party Name/Address</td>
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CMS-1450 (UB-04) Form Locators and Field Description (cont’d):

Form Locator 52  Release of Information Certification Indicator
Form Locator 53  Assignment of Benefits Certification Indicator
Form Locator 54  Prior Payments -- Payer
Form Locator 55  Estimated Amount Due
Form Locator 56  NPI*** (effective 5/23/07)
Form Locator 57  Other Provider ID-Primary/Secondary***
Form Locator 58  Insured's Name***
Form Locator 59  Patient’s Relationship to Insured***
Form Locator 60  Certificate/Social Security Number/Health Insurance Claim/Identification Number***
Form Locator 61  Insured Group Name
Form Locator 62  Insurance Group Number
Form Locator 63  Primary/Secondary/Third
Form Locator 64  Document Control Number
Form Locator 65  Employer Name
Form Locator 66  DX Version Qualifier
Form Locator 67  Principal Diagnosis Code***
Form Locator 67  A-Q Other Diagnosis Codes
Form Locator 68  Unlabeled Field
Form Locator 69  Admitting Diagnosis Code (Inpatient only***)
Form Locator 70  Patient’s Reason for Visit Code
Form Locator 71  PPS Code*** (if in Provider contract with payor)
Form Locator 72  A-C External Cause of Injury Code
Form Locator 73  Unlabeled
Form Locator 74  ICD Code/Date*** (if surgical procedure performed)
Form Locator 74  a-e Other Procedure Code/Date
Form Locator 75  Unlabeled Field
Form Locator 76  1- Attending –NPI/QUAL/ID
Form Locator 76  2- Attending-Last/First
Form Locator 77  1-Operating-NPI/QUAL/ID
Form Locator 77  2-Operating-Last/First
Form Locator 78  1-Other ID-QUAL/NPI/ID
Form Locator 78  2-Other ID-Last/First
Form Locator 79  1-Other ID- QUAL/NPI/QUAL/ID
Form Locator 79  2-Other ID-Last/First
Form Locator 80  1-4 Remarks
Form Locator 81  a-d Code-Code-QUAL/CODE/VALUE

**  Required Fields by Pre Adjudication Edits
***  Required Fields by BCBST/BlueCare Tennessee Electronic Billing

Reminder: To ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted on or after 10/1/2012, with a discharge status 20, 40, 41, or 42 must also include an Occurrence Code 55, and date of death.
M. CMS-1450 Claim-Specific Billing and Reimbursement Requirements

Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and medical policy.

1. Hospital Inpatient Acute Care:
   - Notification is required on all inpatient hospital stays except for maternity cases and when Medicare is the primary insurer.
   - Emergency admissions require notification within 24 hours or the next working day.
   - If a child has not received his/her temporary or permanent TennCare ID number, the Provider is required to request notification using the mother’s ID number.
   - Professional and/or technical components of hospital-based Physicians and CRNA’s must be billed separately on a CMS-1500/ANSI-837P.

The reimbursement mechanism for all inpatient hospital services will be Diagnosis Related Groups (DRG). BlueCare Tennessee’s DRG base rates and outlier per diems for each of the nine CSAs as well as for Rural Referral Centers located in those CSAs are defined in Exhibit B-II of the BlueCare Contract. Base rates and outlier per diems will be paid based on the Provider’s CSA.

The following guidelines are used in administering DRG reimbursement:

- **DRG Assignment and Application**
  BlueCare Tennessee will make DRG assignment via CMS Based Grouper as defined by Provider’s contract purchased from Third Party Software Vendor.

  The DRG assignment will be based on the principal diagnosis, up to twenty-four (24) other secondary diagnoses, additional associated present on admission codes, as well as age, sex, and discharge status of patient. If CMS changes the DRG assignment criteria, BlueCare Tennessee will remain on current grouper assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until such time that the parties mutually agree, the contracted DRGs will be utilized. In the event the parties cannot reach an agreement, the dispute shall be resolved by the Provider Dispute Resolution Procedure as described in this Manual. BlueCare Tennessee will use the DRG grouper, outlier threshold, and other provisions in effect at the time of Member discharge as the basis for payment. However, the base rates and relative weights in effect at the admission date are used to calculate the payment level.

  DRGs, which are deleted by CMS subsequent to the establishment of the schedule, will be removed. For new DRGs added by CMS after the establishment of the schedule, BCT will utilize the initial CMS Relative Weight and ALOS published in the Federal Register.

- **Inlier Payments**
  DRG payments are made on a per discharge basis. A discharge is defined as occurring when a Member is formally released from the hospital, dies in the hospital, or is transferred to another hospital or unit which is excluded from participation in BlueCare Tennessee’s DRG payment system. When a discharge is determined to have occurred, and the patient is not eligible for additional outlier payments, the method of payment is the inlier payment formula. Inlier payments are the standard method of reimbursement for most inpatient hospital stays. It represents a fixed payment to the hospital for handling a particular case based upon the Member’s diagnoses, and any procedure (s) performed. The payment for an inlier is determined by multiplying the DRG base rate times a relative weight factor, and then subtracting any related BlueCare/TennCareSelect Enrollee liability.
The formula for this payment is:
Inlier payment = (Base Rate x Relative Weight) - Enrollee Liability
The Enrollee’s liability will be co-insurance only. These amounts represent the portion of the payment, which is the enrollee’s responsibility based upon the BlueCare/TennCare Select Benefit Agreement. Hospitals are allowed to separately bill for and collect Enrollee liability from the Member. However, because the DRG payment rates are designed to compensate hospitals for a Member’s complete treatment, any charges in excess of the DRG price (base rate x relative weight) are non-reimbursable to the hospital.

➢ Outlier Payments
Outliers are defined as cases involving atypical lengths of stay. A discharge is considered to be an outlier if the Member’s length of stay (excluding non-covered days) exceeds a predetermined threshold.

Hospitals receive an additional per diem payment for each covered day beyond the threshold (any days beyond the threshold require prior authorization). Outlier per diem rates are shown in Exhibit B-II of the BlueCare Attachment.

➢ Inpatient Short Stay Payments
Inpatient stays for Observation will be subject to BlueCare Tennessee’s retroactive audit. Medical records that support the claim will be reviewed to determine if the payment was for services rendered. Where BlueCare Tennessee has paid for services beyond those actually provided, a recovery will be processed in accordance with audit recovery procedures. Providers have the option to file a corrected outpatient claim for the appropriate observation hours.

➢ Expired Patient Payments
If a Member expires after admission, full DRG will be allowed. The patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

➢ Transfer Payments
If a Member is transferred to another facility for the same or similar condition, a discharge as defined under the DRG payment system has not occurred. Cases that have been transferred are considered normal admissions for the receiving Institution and payment to there will be made in accordance with Provider Agreement. The facility transferring the Member is paid based upon outlier per diems not to exceed the appropriate inlier payment. These claims are identified by the Discharge Status Codes filed on the claim as follows: 02, 05, 70 or 82-95. The facility from which the Member is ultimately discharged receives the full DRG payment rate.

When billing for a transfer payment, the appropriate discharge status must be indicated on the CMS-1450 claim in Form Locator 17, or its electronic claims equivalent. BlueCare Tennessee will authorize payment only if:

- The receiving facility initiated and followed the transfer review procedures of BlueCare Tennessee; and the services were Medically Necessary.

➢ Readmissions (Does not apply to CoverKids. See Section VI. Billing & Reimbursement in BCBST Provider Administration Manual for readmissions guidelines for CoverKids)
A readmission is defined as a preventable, unplanned admission occurring within thirty (30) days after a hospital discharge to the same facility for a complication of the original hospital stay or admission resulting from a modifiable cause. This policy applies to all readmissions except those types of readmissions that *may be approved for authorization which are indicated below.

Claims for patients at either a DRG or Per Diem facility that are re-admitted for a condition other than those specified in this policy are not eligible for multiple payments. Only a single payment will be made by BlueCare Tennessee. These guidelines are subject to the Provider’s contract and retrospective claims review and recovery.
Some examples of readmissions that MAY NOT be authorized are:

- respiratory admissions, e.g., COPD;
- complications from surgical procedures; or
- congestive heart failure (CHF).

Some examples of readmissions that MAY be authorized are:

- NICU admissions;
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain;
- children 21 years and under admitted to any facility; or
- admissions for complication due to rejection of transplant/implant surgery.

Note: The Member cannot be held liable for payment of services received when not authorized.

- Left Against Medical Advice
  In the event that a Member discharges himself or herself from the facility, payment will be made based upon outlier per diems not to exceed the appropriate inlier payment. Patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

- Exclusions
  The following conditions and/or treatments are specifically excluded from DRG Reimbursement:

  a) Mental disease and disorders (MDC 19)
  b) Alcohol and drug use (MDC 20)
  c) Rehabilitation

- BlueCare/TennCareSelect Enrollee Liability
  Network Providers may bill and collect from Enrollees only for allowable coinsurance that will be calculated based on the lesser of covered charges or the DRG price.

- Organ Acquisition
  Organ Acquisition costs incurred by facilities for approved BlueCare or TennCareSelect transplants will be paid up to the BlueCare Tennessee corporate maximum of $10,000.00.

- Outpatient Services Treated as Inpatient Services
  Pre-admission Diagnostic Services that are related to the Member’s facility admission performed on an outpatient basis and performed by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility), within three (3) days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period.

  Other Pre-admission Non-Diagnostic Services that are related to the Member’s facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three (3) days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period.
The term “day” refers to the calendar day(s) immediately preceding the date of admission or day following discharge. For example, if a Member is admitted on Wednesday, services provided on Sunday, Monday and/or Tuesday are included in the inlier portion of the DRG payment, as opposed to 72 hours from the admission hour.

Exclusions: Ambulance Services, Chronic Maintenance Renal Dialysis Treatments, Home Health Services, Inpatient Services.

- **Eligibility**
  
  When a Member’s TennCare eligibility begins during a facility confinement, BlueCare Tennessee is obligated to pay for services from the eligibility date forward. A split bill will be requested for days prior to and after the Member’s effective date to determine appropriate charges. BlueCare Tennessee will reimburse the outlier per diem not to exceed the full DRG reimbursement amount.

  When a Member’s eligibility terminates prior to the discharge date (Member was effective at the time of admission, but not through the entire hospital stay), BlueCare Tennessee pays the full DRG amount regardless of termination date.

- **Quality Review**
  
  BlueCare Tennessee will review the validity of the diagnostic information provided by the hospital, the completeness and adequacy of care provided the appropriateness of the admission and discharges, as well as the appropriateness of care provided to Members designated as outliers. If BlueCare Tennessee determines that the Provider has engaged in unacceptable admission, premature discharges, or other practices, which circumvent the DRG payment system, BlueCare Tennessee may disallow, in whole or in part, payment for such services. In addition, BlueCare Tennessee may require the hospital to take corrective actions to prevent or correct the inappropriate practices. A repeated pattern of premature discharges, or other practices, which result in such intended quality of care, may result in termination of their BlueCare or TennCareSelect Attachment.

- **Inpatient Billing Requirements**
  
  * Submit Claims for services provided to BlueCare or TennCareSelect Members using the CMS-1450 claim form or Electronic Claims system.
  * Refer to the Tennessee Uniform Billing Guide (CMS-1450) for specific instructions on claims preparations.
  * Include all inpatient billings and charges for services obtained from another organization related or unrelated while an inpatient at your facility.
  * Indicate if work-related injuries or illnesses are involved.
  * Indicate if the services are related to an accident.
  * Indicate if the BlueCare or TennCareSelect Member has other coverage and if so, the identity of the other coverage or plan.
  * Compute the number of inpatient days. Count the day of admission but not the day of discharge. No charge will be allowed for a fractional part of a day.
  * Submit interim billings for inpatient services after the 30th inpatient day. Continue to use thirty (30) calendar days as the interim billing period. This format applies to inpatient claims only as outpatient claims should not be filed as Interim Bills.
  * Submit all claims within one hundred twenty (120) calendar days of discharge date. If filing a CMS-1450 claim, send it to the claims service center.
  * A split bill is appropriate only when requested by BlueCare Tennessee (BCT). Split bills are used to reflect covered charges allocated for approved and denied days. Split bills that have not been requested by BCT are subject to denial or recovery.

**Note:** Failure to follow these billing requirements or provide all information necessary to adjudicate the claim can result in rejection of claims. Submit claims to:

BlueCare or TennCareSelect Claims Service Center
1 Cameron Hill Cr, Suite 0002
Chattanooga, TN 37402-0002

Rev 06/18
2. Post-Partum Voluntary Reversible Long Acting Contraceptive Reimbursement (PP VRLAC)

Beginning November 1, 2017, BlueCare Tennessee began reimbursing Providers for voluntary reversible long-acting contraceptives (VRLAC) as separate items. Charges for the VRLAC devices implanted during the labor and delivery inpatient stay must be billed as part of the inpatient facility claim using the appropriate HCPCS code. Physicians who perform implants in the hospital will continue to receive reimbursement and should bill the appropriate CPT® code associated with the procedure.

The following is a list of current HCPCS codes that are affected: J7296, J7297, J7298, J7300, J7301, and J7307.

3. Neonatal Services Reimbursement

The Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities set new standards for neonatal intensive care units (NICU) in April 2014. Babies born with certain life-threatening conditions at a standard birth facility should be transferred to the nearest NICU. The facility should code the claim for the care provided and note the baby was transferred to a NICU.

Even though the guidelines changed two years ago, the related reimbursement levels have not been enforced. Babies born in distress are often treated at the standard birth center where they were born and these facilities are reimbursed for NICU-level care.

If your birth facility does not meet the NICU standards, please make sure your claims do not include codes for NICU-level care. All claims are subject to a post-payment audit. Payments for claims that do not comply with Tennessee Perinatal Care Guidelines will be recovered.

4. Policy for Present On Admission (POA) Indicators

This policy applies to claims billed on a CMS-1450/UB-04/ANSI-837I for all BlueCare Tennessee lines of business.

For all inpatient admissions to general acute care hospitals, BlueCare Tennessee began requiring the Present on Admission code on primary and secondary diagnoses (Form Locator 67) for discharges on or after Dec. 31, 2007, by using National Coding Standard guidelines. This may impact reimbursement.

POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum’s (NQF) list of Serious Reportable Events (commonly referred to as “Never Events”), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by The Centers for Medicare & Medicaid Services (CMS) POA Indicator Options:

Present on Admission (POA) Indicator Options:

- Y = Diagnosis was present at time of inpatient admission.
- N = Diagnosis was not present at time of inpatient admission.
- U = Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- 1 = Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.
When filing electronic ANSI 837 inpatient facility claims, providers should no longer enter Indicator Option “1” in the POA field when exempt from POA reporting. The POA field should be left blank for EDI format 5010 claims.

When filing paper CMS-1450 (UB04) inpatient facility claims, providers should enter a “1” in the POA field when exempt from POA reporting.

When any other POA Indicator Options apply, they should be reported in the POA field on both electronic and paper claims.

Claims will reject if:
- POA “1” is submitted on an electronic ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the Centers for Medicare & Medicaid (CMS) website at [www.cms.gov/HospitalAcqCond/](http://www.cms.gov/HospitalAcqCond/).

5. Reimbursement Policy for Selected Hospital Acquired Conditions (HACs) Not Present on Admission (POA)

This policy applies to reimbursement for selected hospital acquired conditions not present on admission billed on a CMS-1450/UB-04/ANSI-837I for all BlueCare Tennessee lines of business.

BlueCare Tennessee will use POA indicators to determine DRG assignment for selected HACs (a.k.a. avoidable hospital conditions) not present on admission as outlined by The Centers for Medicare & Medicaid Services (CMS) National Reimbursement Policy.

The POA indicators are needed when hospital providers bill for selected HACs, including some conditions on the National Quality Forum’s (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by the CMS POA Indicator Options.

Reimbursement for BlueCare and TennCare Select facilities on CMS-DRG (v24 grouper) will be adjusted for the POA impact as directed by the Division of TennCare. Unless further notified by the Division of TennCare, facilities are required to report the POA indicators in accordance with the CMS Billing Guidelines for all BlueCare or TennCare Select facility contracts.

6. Reimbursement Policy for Serious Reportable Adverse Events (Never Events)

This policy applies to reimbursement for Serious Reportable Adverse Events (commonly referred to as "Never Events") billed on a CMS-1450 / ANSI-837I for all BlueCare Tennessee lines of business.

According to the National Quality Forum (NQF), Serious Reportable Adverse Events, (commonly referred to as "never events") are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Therefore, in an effort to reduce or eliminate the occurrence of "never events", BlueCare and TennCare Select will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the never event. BlueCare and TennCare Select have adopted the list of serious adverse events in accordance with the Centers for Medicare & Medicaid Services (CMS) as well as any additional events assigned by the BlueCross BlueShield Association (BCBSA). The list of Serious Reportable Adverse Events can be viewed on the CMS website, [www.cms.gov](http://www.cms.gov).
BlueCare and TennCareSelect will require all participating facilities to report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims. Otherwise, BlueCare and TennCareSelect will follow CMS guidelines for the billing of Never Events. In the instance that the "Never Event" has not been reported, BlueCare and TennCareSelect will use any means available to determine if any charges filed with BlueCare and TennCareSelect meet the criteria, as outlined by the NQF and adopted by CMS, as a Serious Reportable Adverse Event. In the circumstance that a payment has been made for a Serious Reportable Adverse Event, BlueCare and TennCareSelect reserves the right to re-coup the reimbursement as necessary. BlueCare and TennCareSelect will require all participating acute care hospitals to hold Members harmless for any services related to Never Events in any clinical setting.

BlueCare and TennCareSelect follow CMS guidelines for reporting and reimbursement unless otherwise notified by the Division of TennCare.

7. BlueCross BlueShield of Tennessee (BCBST)/BlueCare Tennessee (BCT) Facility Fee Schedule Reimbursement Methodology Policy

This policy applies to claims filed on a CMS-1450 claim form or ANSI/837 Institutional transaction. It defines the reimbursement methodology used for all new codes for BlueCross BlueShield of Tennessee (BCBST) and Medicaid lines of business and existing HCPCS/CPT® codes for BCBST lines of business only that are on the BCBST/BCT Facility Fee Schedule. The purpose is to establish a consistent method to add and update HCPCS/CPT® codes on the BCBST/BCT Facility Fee Schedule for all contracts.

BCBST/BCT will update the BCBST/BCT Facility Fee schedule for quarterly additions and deletions to HCPCS/CPT® codes that are effective January 1, April 1, July 1, and October 1 of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable reimbursed by BCBST/BCT beginning with the effective date of the code from January 1 until March 31 will be considered an interim allowable based on the reimbursement pricing methodology below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the Provider’s contract.

To establish the codes that are added to the BCBST/BCT Facility Fee Schedule, BCBST/BCT will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor. These codes will be updated annually on July 1st from the First Quarter OPTUM Uniform Billing (UB) Editor Updates.

Note: For Medicaid lines of business the following pricing methodology is only used to establish reimbursement for new HCPCS/CPT® codes and codes with no other pricing available. Existing code reimbursement is updated at the discretion of the Division of TennCare.

The reimbursement methodology within this policy does not apply to "C" codes such as drugs, biologicals, radiopharmaceuticals, and devices that have alternate reimbursement methodologies.

The established BCT Facility allowable will be based on the published maximum allowable non-facility rate. BCT will not establish an allowable for an unlisted code. Some exceptions may apply.

To determine the allowable, BlueCare Tennessee will utilize the following reimbursement pricing methodology hierarchy excluding laboratory (see laboratory pricing grid):

<table>
<thead>
<tr>
<th>Order</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Current Year Medicare RBRVS fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.</td>
</tr>
</tbody>
</table>
**Order** | **Description**
--- | ---
2nd | Current Year Medicare RBRVS fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.
3rd | Current Year Palmetto GBA (or its successor) Complete RBRVS TC component x contract multiplier %.
4th | Current Year Palmetto GBA (or its successor) Complete RBRVS *Global x contract multiplier %.
5th | Current Year OPTUM (or its successor) Complete RBRVS TC component x contract multiplier %.
6th | Current Year OPTUM (or its successor) Complete RBRVS *Global (Calculated using the CMS formula) x contract multiplier %.
7th | Current Year National Medicare APC Payment Rate x contract multiplier %.
8th | Allowables that were not priced by any source mentioned above remain at zero dollars with “BR – By report” to be reviewed and priced by using a similar HCPCS/CPT® code.
9th | Last Resort Pricing for eligible services with no other means of pricing:
     - 30% charge for Medicaid lines of business.

*Global represents the 5-digit code on fee schedule with no modifiers

**To determine the allowable, BlueCare Tennessee will utilize the following reimbursement pricing methodology hierarchy for laboratory:**

**Order** | **Description**
--- | ---
1st | Current Year Palmetto GBA (or its successor) Clinical Laboratory fee schedule x contract multiplier %.
2nd | Current Year Medicare Physician fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.
3rd | Current Year Medicare Physician fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.
4th | Current Year Palmetto GBA (or its successor) Physician fee schedule TC component x contract multiplier %.
5th | Current Year Palmetto GBA (or its successor) Physician fee schedule *Global x contract multiplier %.
6th | Current Year OPTUM (or its successor) Complete RBRVS TC component (Calculated using the CMS formula) x contract multiplier %.
7th | Current Year OPTUM (or its successor) Complete RBRVS *Global (Calculated using the CMS formula) x contract multiplier %.
8th | Current Year National Medicare APC Payment Rate x contract multiplier %.
9th | Allowables that were not priced by any source mentioned above remain at zero dollars with “BR – “By report” to be reviewed and priced by using a similar HCPCS/CPT® code.
10th | Last Resort Pricing for eligible services with no other means of pricing:
     - 30 percent of charge for Medicaid lines of business.

*Global represents the 5-digit code on fee schedule with no modifiers

**8. Hospital Outpatient**
- Submit claims for services provided to BlueCare or TennCareSelect Members using the CMS-1450 claim form or Electronic Claims system.
- Refer to the Tennessee Uniform Billing Guide CMS-1450 for specific instructions on claims preparation.
- All professional fees should be billed on the CMS-1500 claim form.
- Professional fees billed on CMS-1450 claim forms will be denied.
- Include the appropriate CPT® or HCPCS code next to each revenue code.
- Indicate if work-related injuries or illnesses are involved.
- Indicate if the BlueCare or TennCareSelect Member has other coverage and if so, the identity of the other carrier or Plan.
- Pharmaceutical and supply items should not be billed separately.
Surgical procedure codes should not be included (Form Locator 74) unless there is a surgery CPT® code filed on the claim.

Note: Failure to follow these rules or provide all information necessary to adjudicate the claim can result in rejection of claims. CMS-1450 claims must be submitted to the claims service center within 120 days of discharge date.

All outpatient revenue codes require a CPT®/HCPCS code EXCLUDING the following:
- 0250-0259 Pharmacy
- 0270-0279 Medical Surgical Supplies & Devices
- 0451 ER Screening
- 0710, 0719 Recovery Room
- 0720-0722 Labor Room/Delivery
- 0729 Other Labor Room/Delivery
- 0760 or 0762 Treatment/Observation Room
- 0912-0913 Day Treatment/Night Treatment

Non-Covered Charges* (Emergency or Non-Emergency):
- RCs 0250 – 0259 Pharmacy;
- RCs 0270 – 0279 Medical and Surgical Supplies; and
- RCs 0290 – 0299 Durable Medical Equipment (DME)

*These charges are considered incidental to the primary services being performed.

9. Hospital Outpatient/Ambulatory Surgery
- Reimbursement made for covered outpatient surgery services will be based on the Outpatient Surgery Procedures Fee Schedule.
- The fee schedule includes all facility services rendered by the surgical facility or any facility wholly owned or operated by the surgical facility on the day of surgery.
- Use the appropriate CPT® code when billing ancillary services.
- Bill professional fees on a CMS-1500 claim form.
- Submit Claims for services provided to BlueCare Members using the CMS-1450 claim form or electronic claims system.
- Refer to the Tennessee Uniform Billing Guide (CMS-1450) for specific instructions on claims preparations.
- Indicate if work-related injuries or illnesses are involved.
- Indicate if the services are related to an accident.
- Indicate if the BlueCare Member has other coverage and if so, identify name of other coverage or plan.
- Bill ancillary services using the appropriate CPT® code (these services include prescribed drugs and supplies).
- Submit CMS-1450 claims to the Claims Service Center within 120 days of discharge date.

Note: Refer to the BlueCare Amendment to the BlueCross BlueShield of Tennessee Institution Agreement, Exhibit B-IV for additional Information.

Submit claims to: BlueCare/TennCareSelect Claims or CoverKids Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37402-0002

Note: Acute Care Providers can file all eligible outpatient minor surgery HCPCS/CPT® codes in conjunction with any active revenue code for proper reimbursement, regardless of date of service.
10. CPT® Code with Surgery Revenue Code

- The Provider must file a surgical RC with a surgical CPT® code range (10000-69999) in order for service to be considered for reimbursement.
- Include the appropriate CPT® code next to each revenue code.
- The revenue codes listed below do not require CPT®/HCPCS codes.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250 — 0259</td>
<td>Pharmacy</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
<tr>
<td>0270 — 0279</td>
<td>Medical Surgical supplies and devices</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
<tr>
<td>0710 — 0719</td>
<td>Recovery Room</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
<tr>
<td>0720 — 0722</td>
<td>Labor Room / Delivery</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
<tr>
<td>0729</td>
<td>Other Labor Room / Delivery</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
<tr>
<td>0760 or 0762</td>
<td>Treatment or Observation Room</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract not to exceed 36 hours</td>
</tr>
</tbody>
</table>

11. Observation Room

Observation services should be billed on a CMS-1450 claim form using Revenue Code 0762. When submitting ANSI 837 electronic claims, the institutional format must be used. Services are reimbursed based on one-hour increments. Each number of service (Form Locator 46) should be equal to one hour in observation.

Example: 1 hour = 1 unit
2 hours = 2 units, etc.

BlueCare Tennessee will allow up to 36 hours for the Observation Services if Medically Necessary and Medically Appropriate. Hours billed in excess of 36 hours will not be allowed.

The following reimbursement rules apply:

- **Observation filed with Emergency Room Services:**
  Observation and all services not considered incidental* to the emergency room visit are reimbursed fee-for-service. Charges billed for use of the emergency room, RC 0450, are considered part of the observation room charge and are not reimbursed separately.

- **Observation filed with Outpatient Surgery:**
  Observation charges (RCs 0729, 0762, 0769) may not be billed until six (6) hours after surgery. Recovery times up to six (6) hours are included in the Outpatient Surgery All-Inclusive Rates.

Reimbursement for Observation will be allowed in addition to the surgery when the claim is filed with an Observation room charge. For multiple surgeries filed on the same claim form with Observation, the highest level code is reimbursed at 100 percent of the Outpatient surgery fee schedule and each additional surgical code is reimbursed at 50 percent of the Outpatient surgery fee schedule. The highest level code is not determined by the greatest total charge but by the highest allowed.

Note: Reimbursement for approved Observation will be paid at the lesser of covered charges.
Observation filed on an Inpatient claim (inpatient setting):
Observation services filed on a CMS-1450 claim form are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

*Incidental services include but are not limited to those services billed under RCs 0250 – 0259 (Pharmacy), 0270 – 0279 (Surgical Supplies), 0290 – 0299 (DME), 0370 – 0379 (Anesthesia), 0510 – 0519 (Clinic Visit), 0637 (Self Administration Drugs), 0710/0719 (Recovery Room), and personal items. (Please note that services such as CT and MRI are considered eligible ancillary services when billed with a revenue code not previously listed as Incidental.)

12. Newborn (Does not apply for CoverKids)
- Reimbursement method: DRG
- TennCare requires that each individual have a unique identification number; therefore parents are required to contact the local Department of Human Services to request a temporary identification number on newborns.
- Claims can be filed under the mother’s unique identification number for thirty (30) calendar days after the birth of the baby. If the baby has been issued a temporary or permanent identification number, claims must be filed using the baby’s identification number. After the initial thirty (30) days, if the newborn’s charges are still filed using the mother’s ID number they will be denied.
- Refer to the ICD Manual for billing of appropriate ICD codes.

13. Clinic Visit (Professional Fees)
- Clinic charges should be billed on a CMS-1500 claim form.
- Other diagnostic or therapeutic services related to the clinic visit may be billed on the same claim on different line items using the appropriate CPT®/HCPCS code.
- Clinic services will be reimbursed at the office visit rate. Only a professional component will be recognized for non-emergent care rendered in the emergency room, urgent care or other outpatient departments of the facility with no separate facility payment being made.

14. Wound Care Reimbursement Rules
BlueCare will only consider reimbursement for Wound Care services specifically listed below:
- Wound Care claims must be billed following the CMS-1450 format.
- Wound Care services are considered all-inclusive.
- Revenue Code (RC) 0420 or 0430 is to be used for HCPCS/CPT® codes 97597, 97598, 97602, 97605, 97606, 97607, 97608 and 29580 when performed by physical or occupational therapists ONLY. Otherwise, RC 0519 should be utilized for all wound care services rendered in a wound care clinic setting, to include HCPCS/CPT® codes 11042, 11043, 11044, 11045, 11046, 11047, 97597, 97598, 97602, 97605, 97606, 97607, 97608, 0491T, 0492T, 0493T and 29580.
- RC 0519 is the appropriate RC to use when filing HCPCS/CPT® code 99211 for Wound Care.
- However, HCPCS/CPT® code 99211 is not to be filed in conjunction with codes 11042, 11043, 11044, 11045, 11046, 11047, 97597, 97598, 97602, 97605, 97606, 97607, 97608 or 29580.
- If services are performed in the operating room, Providers should file with the appropriate Revenue Code to receive surgery grouper allowable.
- Refer to CPT® codes 97597, 97598, 97602, 97605, 97606, 97607 and 97608 for Active Wound Care management services.
- Re-bundling of service will occur if necessary.
- Claims will be subject to retrospective audits.

Note: Prior authorization is required for BlueCare and TennCareSelect Members for hyperbaric oxygen therapy (HBO) procedure code G0277 and services should be billed with RC 0413.
15. Dialysis

- **Composite Rate** – BlueCare Tennessee allows the lesser of total covered charges or a composite rate to include any self-dialysis training session costs or support service fees as negotiated in the contract. Except where specifically noted in the contract, the composite rate includes all routine services, drugs, and supplies associated with dialysis. The composite rate should only be billed to BlueCare Tennessee when an actual dialysis treatment has been performed within the clinic.

Form locators related to the composite rate should be completed on the CMS-1450 as described in the following table. Use ANSI-837-I when submitting electronic claims.

<table>
<thead>
<tr>
<th>Service</th>
<th>Condition Code FL 39-41</th>
<th>Revenue Code FL 42</th>
<th>Unit/ Frequency FL 46</th>
<th>Composite Rate FL 47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis – Method I or II Composite Rate</td>
<td>71, 73, 74, or 76</td>
<td>082X</td>
<td>Per Visit</td>
<td>Composite Rate</td>
</tr>
<tr>
<td>Peritoneal Dialysis - Method I or II Composite Rate</td>
<td>71, 73, 74, or 76</td>
<td>083X</td>
<td>Per Visit</td>
<td>Composite Rate</td>
</tr>
<tr>
<td>CAPD - Method I or II Composite Rate</td>
<td>73 or 74</td>
<td>084X</td>
<td>Per Visit</td>
<td>Composite Rate</td>
</tr>
<tr>
<td>CCPD - Method I or II Composite Rate</td>
<td>73 or 74</td>
<td>085X</td>
<td>Per Visit</td>
<td>Composite Rate</td>
</tr>
</tbody>
</table>

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made.

- **Erythropoietin (EPO)** – BlueCare Tennessee will allow for EPO to be paid in addition to the composite rate. The appropriate value code should be billed in FL 39-41 in conjunction with the appropriate revenue code, 0634 or 0635 in FL 42. The HCPCS code associated with the EPO should be included in Field 44. FL 46 for Units of Service should be completed in accordance with Healthcare Common Procedure Coding System (HCPCS). Total charges should be billed in FL 47. Total charges should not exceed the amount agreed to in the contract. Excess amounts are subject to recovery by BlueCare Tennessee.

- **Laboratory, drugs and blood** – BlueCare Tennessee will allow for eligible non-routine laboratory, injectable drugs and blood in addition to the composite rate. The appropriate value code should be billed in FL 39-41 for blood charges. The relevant CPT® or HCPCS code is required in FL 44 for laboratory and drug charge reimbursement. Units should be billed in FL 46 in accordance with the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS), whichever is appropriate. The following table defines the revenue codes to which BlueCare Tennessee has the respective fee schedules attached. To adjudicate, the claim should be filed as indicated.

<table>
<thead>
<tr>
<th>Fee Schedules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Code FL 42</td>
</tr>
<tr>
<td>0300</td>
</tr>
<tr>
<td>0301</td>
</tr>
<tr>
<td>0302</td>
</tr>
<tr>
<td>0303</td>
</tr>
<tr>
<td>0304</td>
</tr>
<tr>
<td>0305</td>
</tr>
<tr>
<td>0306</td>
</tr>
<tr>
<td>0307</td>
</tr>
</tbody>
</table>
BlueCare Tennessee
Provider Administration Manual

Fee Schedules

<table>
<thead>
<tr>
<th>Revenue Code FL 42</th>
<th>Service</th>
<th>Description</th>
<th>HCPCS/ Rates FL 44</th>
<th>Service/ Units FL 46</th>
<th>Total Charges FL 47</th>
</tr>
</thead>
<tbody>
<tr>
<td>0309</td>
<td>Laboratory</td>
<td>Other</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
</tr>
<tr>
<td>0310</td>
<td>Laboratory Pathological</td>
<td>General</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0311</td>
<td>Laboratory Pathological</td>
<td>Cytology</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0312</td>
<td>Laboratory Pathological</td>
<td>Histology</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<td>Laboratory Pathological</td>
<td>Biopsy</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<td>Laboratory Pathological</td>
<td>Other</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0390</td>
<td>Blood Storage and Processing</td>
<td>General</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0391</td>
<td>Blood Storage and Processing</td>
<td>Blood administration</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0399</td>
<td>Blood Storage and Processing</td>
<td>Other blood storage and processing</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0636</td>
<td>Drugs Requiring Specific Identification</td>
<td>Drugs Requiring Detailed Coding</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0380</td>
<td>Blood</td>
<td>General</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
</tr>
<tr>
<td>0381</td>
<td>Blood</td>
<td>Packed Red Cells</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<tr>
<td>0382</td>
<td>Blood</td>
<td>Whole Blood</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
</tr>
<tr>
<td>0383</td>
<td>Blood</td>
<td>Plasma</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
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<tr>
<td>0384</td>
<td>Blood</td>
<td>Platelets</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<td>0385</td>
<td>Blood</td>
<td>Leukocytes</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<td>0386</td>
<td>Blood</td>
<td>Other Components</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
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<td>0387</td>
<td>Blood</td>
<td>Other Derivatives</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
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<tr>
<td>0389</td>
<td>Blood</td>
<td>Other</td>
<td>Fee Schedule</td>
<td>Appropriate Charges</td>
<td></td>
</tr>
</tbody>
</table>

- **Member Benefits and Medical Policy** — Presence of a fee is not a guarantee the procedure, service or item will be eligible for reimbursement. Final reimbursement determinations are based on Member eligibility on the date of service, Medical Necessity, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitation, authorization/referral requirements and BlueCare Tennessee Medical Policy.

- **Non-Reimbursable Revenue Codes** — Unless specifically indicated in the Network Attachment, BlueCare Tennessee will not reimburse for services billed in addition to the composite rate. In order to administer the contract, BlueCare Tennessee does not utilize the general revenue codes. Detail revenue codes are required.

The following table addresses dialysis-related revenue codes that are considered to be part of the composite rate or are not utilized by BlueCare Tennessee. This list is not intended to be all-inclusive.

### Non-Reimbursable Revenue Codes (not all-inclusive)

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Service Description</th>
<th>Pricing Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800</td>
<td>Inpatient Renal Dialysis General</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0801</td>
<td>Inpatient Renal Dialysis Hemodialysis</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0802</td>
<td>Inpatient Renal Dialysis Prtomeal (Non-CAPD)</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0803</td>
<td>Inpatient Renal Dialysis Continuous Ambulatory Peritoneal Dialysis (CAPD)</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0804</td>
<td>Inpatient Renal Dialysis Continuous Cycling Peritoneal Dialysis (CCPD)</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0809</td>
<td>Inpatient Renal Dialysis Other</td>
<td>$0.00 Not allowed under the contract</td>
</tr>
<tr>
<td>0820</td>
<td>Hemodialysis General</td>
<td>$0.00 Not allowed under contract</td>
</tr>
<tr>
<td>0824</td>
<td>Hemodialysis Maintenance/100%</td>
<td>$0.00 Incidental to the composite rate</td>
</tr>
<tr>
<td>0825</td>
<td>Hemodialysis Support Services</td>
<td>$0.00 Incidental to the composite rate</td>
</tr>
</tbody>
</table>
### 16. Hospice

All Hospice services require notification and must be billed in accordance with BlueCare Tennessee Billing Guidelines.

To facilitate claims administration, a separate line item must be billed for each date of service ONLY if there is a break in the Member’s stay.

Hospice Providers are reimbursed one Per Diem rate on any day, excluding nursing home patients without Medicare benefits.

Reimbursement for inpatient room and board is considered for nursing home residents without Medicare benefits, when authorized, and submitted with revenue code 0658.

Hospice only services for these Members are to be filed using revenue code 0651.

See following table for Revenue Codes and descriptions/service:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description ~ Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>Routine Home Care (RHC) – less than 8 hours of care (1 day = 1 unit)</td>
</tr>
<tr>
<td>0652</td>
<td>Continuous Home Care Full Rate = 24 hours of care based on an hourly rate. A separate</td>
</tr>
<tr>
<td></td>
<td>line item must be billed for each date of service using the appropriate number</td>
</tr>
<tr>
<td></td>
<td>of units in the unit field. (Billed in 15 minute increments)</td>
</tr>
<tr>
<td>0653</td>
<td>Invalid</td>
</tr>
<tr>
<td>0654</td>
<td>Invalid</td>
</tr>
<tr>
<td>0658</td>
<td>Inpatient Room &amp; Board for nursing home residents (a separate claim form must be</td>
</tr>
<tr>
<td></td>
<td>filed for all other services rendered, including Hospice services.)</td>
</tr>
<tr>
<td>0655</td>
<td>Inpatient Respite Care – Family member or other caregiver requiring a short relief</td>
</tr>
<tr>
<td></td>
<td>period (limited to 5 consecutive days)</td>
</tr>
</tbody>
</table>
Revenue Code | Description ~ Service
--- | ---
0656 | General Inpatient Care – Inpatient stays, which meet the criteria for general inpatient care. Exclusions include, but are not limited to:
- Respite care
- Medicare Dual-Eligible
- Nursing home residents

Providers must file BlueCare and TennCare Select claims for Inpatient Room and Board for nursing home residents using Revenue Code 0658 instead of Revenue Code 0654. Claims filed with both Inpatient (Room & Board) and Outpatient (Hospice) charges on the same claim will be denied.

For Continuous Home Care (CHC) only (RC 0652), one unit will equal to 15 minutes. Continuous Home Care (RC 0652) will not be reimbursed when less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day.

Effective January 1, 2016, dates of service and after, BlueCare Tennessee implements the CMS rule changing the payment methodology for RHC (RC 0651) as follows:

- Day 1- 60: Allow higher rate based on admission date.
- Day 61- thereafter: Allow lower rate based on admission date.
- Service Intensity Add-on (SIA Payment):
  - SIA payment is equal to RC 0652 hourly rate for services billed by either RC 0561-Social Worker Services or RC 0551-Registered Nurse visits for a maximum of combined 4 hours per day with a minimum of 1 unit to a maximum of 16 units billed. These services are only eligible when billed in conjunction with RHC services. To receive the SIA add-on payment, claims must include the appropriate discharge status code and only applies when these services are performed within the last seven (7) days of life.

BlueCare Tennessee will utilize the Medicaid Hospice rates for Continuous Home Care, Inpatient Respite Care and General Inpatient Care based on formulas using the Center for Medicare & Medicaid Services (CMS) methodology and the Member’s County code that reflect compliance with the quality Reporting requirements.

Note: Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., $8.7110 would reimburse as $8.72).

Hospice claims must be billed on a CMS-1450 claim form. When submitting ANSI 837 electronic claims, the Institutional format must be used. Providers may bill with either Type of Bill 081x or 082x for both inpatient and outpatient in Form Locator 4 as long as the inpatient and outpatient services are on separate claims. The Statement From/Thru Dates must also correspond with the total days billed on the inpatient care.

Hospice claims should be billed with the Hospice provider number and/or NPI referenced in the Network Attachment. The related levels of care outlined in the Hospice Fee Schedule should be billed according to the table listed above.

Providers are contractually obligated to provide service at the agreed upon rates regardless of patient acuity.

Reimbursement is based on the Hospice Fee Schedule.

Allowed amounts are all-inclusive with the exception of Practitioner services not related to Hospice care. This includes, but is not limited to Hospice Practitioner services, drugs, DME, medical supplies, etc. Practitioner services not related to Hospice care are excluded from the Hospice allowed amounts and should be billed to BlueCare Tennessee on a CMS-1500 claim form. When submitting ANSI 837 electronic claims, the Professional format must be used.
17. **Rehabilitative Care**

**Inpatient Services:**
- Facility will be fully compensated for facility services and supplies directly related to the Rehabilitative Care Services.
- Facilities that are participating as a rehabilitative Provider should use their unique rehabilitative provider number and/or NPI when billing services.
- Reimbursement during therapeutic leave of absence will be reimbursed per diem, and limited according to the following guidelines:
  - No charge made or billed to BlueCare or the Member on the day of departure of a therapeutic leave if the Member does not return to the facility on that date.
  - The full amount can be billed on the day of return from a therapeutic leave, which began on a prior date, providing the Member is not discharged later that day.
  - For therapeutic leaves, which begin, and end on the same day (regardless of the length of time), the amounts should be reduced by fifty (50%) percent and billed accordingly.

**Residential Treatment Center Services:**
- Facility will be fully compensated for facility services directly related to the Residential Treatment Center Services.
- Facilities that are participating as a Residential Treatment Center Services Provider should use their unique Behavioral Facility provider number and/or NPI when billing services.
- Reimbursement during therapeutic leave of absence will be reimbursed per diem, and limited according to the following guidelines:
  - No charge made or billed to BlueCare or the Member on the day of departure of a therapeutic leave if the Member does not return to the facility on that date.
  - The full amount can be billed on the day of return from a therapeutic leave, which began on a prior date, providing the Member is not discharged later that day.
  - For therapeutic leaves, which begin, and end on the same day (regardless of the length of time), the amounts should be reduced by fifty (50%) percent and billed accordingly.

**Partial Hospitalization:**
- Facility will be fully compensated for all facility and professional services and supplies directly related to Rehabilitative Services.

**Rehabilitative/Partial Hospital Services (Reimbursement method is based on per diem and should not be billed with CPT® or HCPCS Codes):**
- Inpatient and Outpatient Professional Rehabilitative Care Services are based on the facility fee schedule.
- Facilities participating as Rehabilitative Providers should use their unique rehabilitative provider number and/or NPI when billing services.

**Rehabilitative Outpatient Professional Services (Reimbursement method is based on the facility Fee Schedule and should be billed with CPT® codes).**

**Home Health and Private Duty Nursing**

*Note:* In order to comply with NUBC guidelines, providers should use TOB 032X for claims filed for home health services.

All Home Health and Private Duty Nursing services should be billed on the CMS-1450 claim format. When submitting ANSI 837 electronic claims, the Institutional format must be used.

Billing of home health agency visits for therapy or medical social service requires only the appropriate Revenue codes and billing units described below. The use of a HCPCS procedure code in billing for these services is optional.
Both the Revenue and HCPCS procedure codes are required for billing of Intermittent visits, Extended visits and Private Duty services. Home Health visits and Private Duty Nursing services are to be billed using the following Revenue codes, HCPCS codes and billing units:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency Visits</td>
<td>Physical Therapy</td>
<td>0421</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
<td>0431</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Speech Therapy</td>
<td>0441</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Medical Social Services</td>
<td>0561</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Intermittent Visits</td>
<td>Skilled Nursing Visit (RN)</td>
<td>0551</td>
<td>G0299</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Visit (LPN)</td>
<td>0551</td>
<td>G0300</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td></td>
<td>Home Health Aid Visit</td>
<td>0571</td>
<td>G0156</td>
<td>1 unit/15 minute</td>
</tr>
<tr>
<td>Home Health Extended Visits</td>
<td>Skilled Nursing Hour (RN)</td>
<td>0552</td>
<td>S9123</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Hour (LPN)</td>
<td>0552</td>
<td>S9124</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td></td>
<td>Home Health Aide Hour</td>
<td>0572</td>
<td>S9122</td>
<td>1 unit/1 hour</td>
</tr>
<tr>
<td>Private Duty</td>
<td>Private Duty Nursing</td>
<td>0589</td>
<td>T1000</td>
<td>1 unit/15 minute</td>
</tr>
</tbody>
</table>

Extended visits are to be billed in whole hour increments. Fractional hours should be rounded to the nearest whole hour (e.g. 1 hour 15 minutes should be rounded to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 30 minutes should be rounded to 2 units, 1 hour 31 minutes should be rounded to 2 units, 1 hour 45 minutes should be rounded to 2 units).

Home Health visits and Private Duty Nursing services not billed with the indicated revenue codes will be rejected or denied.

The billing week is defined as Monday through Sunday. A separate claim is required for each billing week. Each home health service requires a separate claim line item for each date of service in the billing week. Submission of more than one claim per week will result in denial of the second and subsequent claims for that service week.

Intermittent visits, Extended visits and Private Duty Nursing services provided to multiple Members in the same location may require authorization and are to be billed with the following modifiers appended to HCPCS code per line item for each Member’s claim as appropriate:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN</td>
<td>Two patients served</td>
</tr>
<tr>
<td>UP</td>
<td>Three patients served</td>
</tr>
<tr>
<td>UQ</td>
<td>Four patients served</td>
</tr>
<tr>
<td>UR</td>
<td>Five patients served</td>
</tr>
<tr>
<td>US</td>
<td>Six or more patients served</td>
</tr>
</tbody>
</table>

The only supplies that may be billed in addition to the above services are those indicated on the following BlueCare Tennessee Home Health Agency Non-Routine Supply List:
The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:

<table>
<thead>
<tr>
<th>A4212</th>
<th>A4331</th>
<th>A4357</th>
<th>A4375</th>
<th>A4390</th>
<th>A4407</th>
<th>A4422</th>
<th>A4455</th>
<th>A5056</th>
<th>A5105</th>
<th>A7503</th>
<th>A7527</th>
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<tr>
<td>A4248</td>
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<td>A4408</td>
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<td>A5112</td>
<td>A7504</td>
<td>S8185</td>
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<td>A4310</td>
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<td>A4377</td>
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<td>A4409</td>
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<td>A4459</td>
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<td>A7505</td>
<td>S8210</td>
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<td>A4311</td>
<td>A4338</td>
<td>A4361</td>
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<td>A4393</td>
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<td>A4461</td>
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<td>A5114</td>
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<td>A5126</td>
<td>A7509</td>
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<td>A4388</td>
<td>A4405</td>
<td>A4419</td>
<td>A4434</td>
<td>A5054</td>
<td>A5093</td>
<td>A7501</td>
<td>A7524</td>
<td>T4530</td>
<td></td>
</tr>
<tr>
<td>A4330</td>
<td>A4356</td>
<td>A4373</td>
<td>A4389</td>
<td>A4406</td>
<td>A4420</td>
<td>A4435</td>
<td>A5055</td>
<td>A5102</td>
<td>A7502</td>
<td>A7526</td>
<td>T4531</td>
<td></td>
</tr>
</tbody>
</table>

The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

<table>
<thead>
<tr>
<th>A6010</th>
<th>A6205</th>
<th>A6221</th>
<th>A6237</th>
<th>A6252</th>
<th>A6407</th>
<th>A6450</th>
</tr>
</thead>
<tbody>
<tr>
<td>A6011</td>
<td>A6206</td>
<td>A6222</td>
<td>A6238</td>
<td>A6253</td>
<td>A6410</td>
<td>A6451</td>
</tr>
<tr>
<td>A6021</td>
<td>A6207</td>
<td>A6223</td>
<td>A6239</td>
<td>A6254</td>
<td>A6412</td>
<td>A6452</td>
</tr>
<tr>
<td>A6022</td>
<td>A6208</td>
<td>A6224</td>
<td>A6240</td>
<td>A6255</td>
<td>A6413</td>
<td>A6453</td>
</tr>
<tr>
<td>A6023</td>
<td>A6209</td>
<td>A6228</td>
<td>A6241</td>
<td>A6256</td>
<td>A6441</td>
<td>A6454</td>
</tr>
<tr>
<td>A6024</td>
<td>A6210</td>
<td>A6229</td>
<td>A6242</td>
<td>A6258</td>
<td>A6442</td>
<td>A6455</td>
</tr>
<tr>
<td>A6154</td>
<td>A6211</td>
<td>A6230</td>
<td>A6243</td>
<td>A6259</td>
<td>A6443</td>
<td>A6456</td>
</tr>
<tr>
<td>A6196</td>
<td>A6212</td>
<td>A6231</td>
<td>A6244</td>
<td>A6261</td>
<td>A6444</td>
<td>A6457</td>
</tr>
<tr>
<td>A6197</td>
<td>A6213</td>
<td>A6232</td>
<td>A6245</td>
<td>A6262</td>
<td>A6445</td>
<td>A6545</td>
</tr>
<tr>
<td>A6198</td>
<td>A6214</td>
<td>A6233</td>
<td>A6246</td>
<td>A6266</td>
<td>A6446</td>
<td>A7040</td>
</tr>
<tr>
<td>A6199</td>
<td>A6215</td>
<td>A6234</td>
<td>A6247</td>
<td>A6402</td>
<td>A6447</td>
<td>A7041</td>
</tr>
<tr>
<td>A6203</td>
<td>A6219</td>
<td>A6235</td>
<td>A6248</td>
<td>A6403</td>
<td>A6448</td>
<td>A7048</td>
</tr>
<tr>
<td>A6204</td>
<td>A6220</td>
<td>A6236</td>
<td>A6251</td>
<td>A6404</td>
<td>A6449</td>
<td></td>
</tr>
</tbody>
</table>

Supplies on the BlueCare Tennessee Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be located in the HCPCS manual.

Supplies not billed with the indicated revenue codes and HCPCS codes will be rejected or denied.
Reimbursement for supplies not indicated on the BlueCare Tennessee Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health or Private Duty Nursing service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit or Private Duty Nursing service are the responsibility of the Home Health Agency.

Supplies not used in conjunction with a Home Health visit or Private Duty Nursing service are not billable by the Home Health Agency or Private Duty Nursing provider.

Refer to the General Billing Information section of this Manual for additional billing guidelines.

### 18. Home Obstetrical Management

All Home Obstetrical Management services should be billed on the CMS-1450 claim form using Type of Bill 33X. When submitting ANSI-837 electronic claims, the Institutional format must be used.

Home Obstetrical Management services must be billed using the following revenue codes, procedure codes, and billing units:

<table>
<thead>
<tr>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home management of preterm labor</td>
<td>0559</td>
<td>S9208</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of gestational hypertension</td>
<td>0559</td>
<td>S9211</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of preeclampsia</td>
<td>0559</td>
<td>S9213</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of gestational diabetes</td>
<td>0559</td>
<td>S9214</td>
<td>1 unit per day</td>
</tr>
</tbody>
</table>

Home Obstetrical Management services not billed with the indicated revenue codes and procedure codes will be rejected or denied. To facilitate claims administration, a separate line item must be billed for each date of service for the above services.

The maximum allowable for Home Obstetrical Management services per diems constitutes full reimbursement for all administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment.

The per diem does not include home health agency skilled nursing (RN or LPN) visits. Home health agency skilled nursing (RN or LPN) visits should be billed in accordance with the BlueCare Tennessee Home Health Billing Guidelines.

### 19. Chemotherapy

The following guidelines apply when billing for chemotherapy filed on a CMS-1450 claim form:

#### Acute Care

- **Injections**
  - Use Revenue Code 0331 with HCPCS Code Q0083 for the administration fee.
  - Use Revenue Code 0636 with one or more of the most appropriate CPT® or HCPCS code for the drug when filing the injection of chemotherapy.

  **Note:** Code Q0083 reimburses the facility for the administration fee, whereas the CPT® or HCPCS code reimburses the facility for the drug.

- **Oral Dosage**
  - Use Revenue Code 0332 with HCPCS Code Q0083 for the administration fee.
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- Use Revenue Code 0636 with one or more of the most appropriate CPT® or HCPCS code for the drug when filing the oral dosage of chemotherapy. (See St. Anthony’s CMS-1450 Editor for determination of the most appropriate CPT® or HCPCS code.)

  **Note:** Code Q0083 reimburses the facility for the administration fee, whereas the CPT® or HCPCS code reimburses the facility for the drug.

- **IV**
  - Use Revenue Code 0335 with HCPCS Code Q0084 or Q0085 for the administration fee.
  - Use Revenue Code 0636 with one or more of the appropriate J Codes for the drug when filing for the IV of chemotherapy. (See St. Anthony’s CMS 1450 Editor for determination of most appropriate CPT® or HCPCS code.)

  **Note:** Code Q0084 or Q0085 reimburses the facility for the administration fee, whereas the CPT® or HCPCS code reimburses the facility for the IV drug.

**Skilled Nursing Facility**

- Use Revenue Code 0636 with most appropriate CPT® or HCPCS code for intravenous chemotherapy when billing for outpatient services. For reporting inpatient services, use Revenue Code 0250 to report chemotherapy, oral cancer drugs, and antientics. No HCPCS Codes are required.

20. Skilled Nursing Facility

Charges for all skilled nursing services should be billed on a CMS-1450 Claim Form according to the level(s) of care for which the facility is contracted with BlueCare Tennessee.

When filing claims for skilled nursing services, facilities are required to:

- provide their BlueCare Tennessee provider number in Form Locator 51 (Health Plan ID) on all CMS-1450 Claim Forms;
- include the appropriate information for the facility’s contracted level(s) of care (see following table);
- obtain prior authorization for all skilled nursing admissions (must obtain prior to scheduled admission or within 24 hours of emergent admissions). Please refer to Section I. of this manual for Prior Authorization telephone numbers.
- File Inpatient services with a Type of Bill 21X or 22X in Form Locator 4; Outpatient services must be billed with a Type of Bill 23X (may be different for Home and Community-Based Service Program – CHOICES) – see Section VIII in this Manual).

The following billing information is required based on the facility inpatient level(s) of care:

<table>
<thead>
<tr>
<th>Type of Bill (FL 4)</th>
<th>Revenue Code (FL 42)</th>
<th>Description (FL 43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21X or 22X</td>
<td>0191</td>
<td>Level I – Skilled Care</td>
</tr>
<tr>
<td>21X or 22X</td>
<td>0192</td>
<td>Level II – Comprehensive Care</td>
</tr>
<tr>
<td>21X or 22X</td>
<td>0193</td>
<td>Level III – Complex Care</td>
</tr>
</tbody>
</table>

**Note:** The third numeral (x) represents the Type of Bill’s Definition for Frequency according to the CMS-1450 Manual. Approved outliers should be billed using the appropriate HCPCS or CPT® code.

21. Guidelines for Appropriate Use of G0128

- G0128 is defined as direct (face to face with one patient at a time) skilled nursing services of a registered nurse provided in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes.

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G0128 is used to bill for services that are specified in the Member’s Plan of Treatment that are not considered incidental to other services. Examples of services that cannot be billed under G0128 are:

- If a nurse participates in a Physician service, e.g. taking the history or reviewing medication as part of an evaluation and management visit or as part of a service during the global surgical period, assisting in a procedure, teaching the patient regarding a procedure or treatment suggested during the Physician or other Practitioner visit; or responding to telephone calls resulting from the Physician visit, then the nursing services are part of the Physician visit and cannot be separately billed by the CORF;
- If a nurse takes vital signs (pulse, blood pressure, weight, respiratory rate) associated with a Physician or therapy visit, this time cannot be billed using G0128;
- If a wound dressing is required after a debridement or whirlpool treatment and the nurse dresses the wound, the payment for the dressing change is included in the code for debridement or whirlpool and cannot be separately billed under G0128; and
- Collecting a laboratory specimen, including phlebotomy.

Co-treatment by a nurse with a physical or occupational therapist or speech and language pathologist, generally will not be allowed unless a separate nursing service is clearly identifiable in the Plan of Treatment and in the documentation.

The definition of skilled services is that it generally requires the skill of a registered nurse to perform the service. Some examples would include procedures such as insertion of a urinary catheter, intramuscular injections, bowel disimpaction, nursing assessment, and education. Education, for example, would include teaching a patient the proper technique for “in and out” urethral catheterization, skin care of decubitus ulcer, and care of a colostomy.

Administrative tasks or documentation should not be billed under G0128.

G0128 cannot be billed with any other codes other than supplies and 99211 (office or other outpatient visit for an established patient, which may not require the presence of a Physician, 5 minutes performing or supervising service).

G0128 can be billed when a registered nurse provides direct (face to face with the patient) skilled nursing services in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes. The first 5 minutes can be billed with CPT® code 99211.

Practitioner cannot bill for these codes.

G0128 cannot be billed when debridement services are performed.

22. **Outpatient Rehabilitation Billing Guidelines**

Freestanding Inpatient Rehabilitation facilities, Freestanding Outpatient Rehabilitation facilities, and Skilled Nursing facilities should bill BlueCare Tennessee for services rendered on a CMS-1450/ANSI-837 Institutional Transaction (UB-92 or its successor) claim form. In general the UB National Uniform Billing Guide should be followed. For those providers filing electronic claims, please refer to the Electronic Billing Instruction section in this Manual.

Only those HCPCS and CPT® codes related to Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, and/or Wound Care* Services should be billed in conjunction with BlueCare Tennessee Rehabilitation Fee Schedules. Services billed outside of the agreement are subject to recovery.

*Refer to Wound Care Reimbursement Rules in this Manual.

Outpatient Rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:
Type of Bill                    Type of Facility
13X Freestanding Inpatient Rehabilitation Facilities
Providing outpatient therapy services
23X Skilled Nursing Facilities
Providing outpatient therapy services
74X or 75X Freestanding Outpatient Rehabilitation Facilities

The appropriate revenue code should be billed according to the following:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0270**</td>
<td>General Supplies</td>
</tr>
<tr>
<td>041X</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>042X</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>043X</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>047X</td>
<td>Audiology</td>
</tr>
<tr>
<td>044X</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>0519</td>
<td>Wound Care/Clinic Visit</td>
</tr>
<tr>
<td>0623</td>
<td>Surgical Dressings</td>
</tr>
</tbody>
</table>

**When supplies are considered eligible for reimbursement

**Electronic Billing Instruction**
For those facilities wishing to submit claims electronically, additional information can be obtained from BlueCross BlueShield of Tennessee eBusiness Solutions Department at:

BlueCross BlueShield of Tennessee
Attn: eBusiness Provider Solutions
1 Cameron Hill Cr, Ste 0007
Chattanooga, TN. 37402-0007

Phone: 423-535-5717 (Option 2)   Fax: 423-535-7523   e-mail: ecomm_support@bcbst.com

23. Multiple Procedures
This policy applies to multiple procedures billed on a CMS-1450/ANSI-837I claim form.

The maximum allowable for eligible multiple procedures billed on the same date of service by the same provider will be based on the lesser of covered charges or 100 percent of the base maximum allowable for the primary procedure and the lesser of covered charges or 50 percent of the base maximum allowable for the secondary and each subsequent procedure.

The primary procedure will be determined by the code with the greatest base maximum allowable.

24. Bilateral Procedures
The aggregate maximum allowable for eligible bilateral procedures will be based on the lesser of covered charges or 150 percent of the base maximum allowable. When a bilateral procedure is performed in conjunction with other surgeries, the reimbursement for the bilateral procedure will be the lesser of covered charges or 75 percent of the fee schedule, when determined that the bilateral procedure is not the primary procedure.

Per HIPAA guidelines, bilateral procedures filed on a CMS-1450 claim form/ANSI 837 Institutional Transaction must be filed as a single item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported. For BlueCare Tennessee, only surgical procedures filed on a facility claim form as indicated above will receive bilateral reimbursement.

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However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples are when, but not limited to:

- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm);
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”.

Therefore, sometimes it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit;
- a single line with modifier 50 and 1 unit; and/or
- if procedure is “other” than surgical such as radiology CPT® codes, bill as two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

25. Surgical Implants

BlueCare Tennessee will reimburse acute care and ambulatory surgical facilities for surgical implants (when criteria are met) when part of an outpatient surgery procedure. The reimbursement will be in addition to the outpatient surgery procedure rate.

BlueCare Tennessee will reimburse for surgical implants at the cost of the device (excludes shipping & handling, and state sales tax) based on manufacturer’s invoice, which is to indicate all discounts and/or rebates. If multiple items are on the manufacturer’s invoice, the correct item(s) is to be clearly indicated.

A surgical implant is defined as a device that is Medically Necessary and Medically Appropriate, which is surgically placed internally for therapeutic or reconstructive purposes and not considered a prosthetic or orthotic device and remains in place after the postoperative period.

BlueCare Tennessee will only consider reimbursement for the implants when the implant is not included in the code descriptor for the service (e.g., intraocular lens, etc.).

**Note:** BlueCare Tennessee requires Providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on CMS-1450/ANSI 837I facility claim forms for Implant Revenue Codes, 0275 and 0278. When a claim is received without an appropriate HCPCS code, the claim line item will be denied Y74 “revenue code requires HCPCS code”. The Provider must submit a corrected claim that includes the appropriate HCPCS code. This guideline is applicable to Outpatient claims.

**Note: Coronary Stents**

BlueCare Tennessee reimburses for coronary stents (when criteria are met) if performed as an outpatient surgical procedure. The reimbursement will be in addition to the procedure rate. BlueCare Tennessee will reimburse for coronary stents at the cost of the device (excludes shipping & handling, and state sales tax) based on manufacturer’s invoice, which is to indicate all discounts and/or rebates. If multiple items are on the manufacturer’s invoice, the correct item(s) must be clearly indicated.

26. Guidance on Billing Incremental Versus Per Diem

There are a number of behavioral health program services that are commonly contracted with both incremental and per diem billing options. Including both methodologies on the fee schedule offers Providers flexibility in billing those services appropriately based on the intensity and duration of services delivered in a day’s time. For instance, Psychiatric Rehabilitation service delivery can vary greatly from day to day based on program design, a Member’s progression in his/her recovery, and the actual array of services that are included in his/her treatment plan at any given time. A Member who is in the early stages of recovery may participate in a psychiatric rehabilitation program for several hours a day. Conversely, a Member who has progressed in his/her recovery and is able to work part time may only need to participate in certain psychiatric rehabilitation activities of short duration and intensity.

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V-125
A daily maximum allowable amount will be applied to claims received for services that can be billed as either per diem or in increments. In general, the maximum allowable amount will be the per diem rate for the service. Codes included under this claims payment rule include:

<table>
<thead>
<tr>
<th>Service Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2017/H2018</td>
<td>Psychiatric Rehabilitation (per diem is inclusive of all components except Supported Housing)</td>
</tr>
<tr>
<td>H2023/H2024</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>H0036/H0037</td>
<td>Comprehensive Child and Family Treatment/Continuous Treatment Team (CCFT/CTT)</td>
</tr>
<tr>
<td>S9482/T2025</td>
<td>Family Support Specialist Services</td>
</tr>
</tbody>
</table>

Additionally, Providers of these services will be subject to audits of per diem billing to determine that the intensity/duration of service delivered justifies a per diem reimbursement. For example, if the incremental rate for CTT services is $15.00 and the per diem rate is $60.00, the duration of service delivery documented should indicate at least one (1) hour (four (4) units) of service for the date billed.

27. CMS-1450 specific Billing Tips

- Use specific CPT® or HCPCS codes - Avoid the use of non-specific or “catch-all” codes (e.g., 99070).
- Use the most current CPT® and HCPCS codes, and ICD codes. Out-of-date codes will be returned.
- For attending and other Physicians, the attending Physician Name and NPI/QUAL/ID should be entered in Form Locator 76, 77, and 78 respectively. (If NPI/QUAL/ID is NOT available, enter “OTH000”).
- Do NOT use Medicaid provider numbers. Submit all claims with your BlueCare assigned provider number and/or NPI.
- All claims must be submitted with the BlueCare Member ID number including the three-letter alpha prefix.
- Verify other insurance information entered on claim.
- Submit separate claims for services rendered to the mother and newborn.
- Interim billings for inpatient DRG admissions should be submitted in 30-day intervals.
- Outpatient claims should not be filed as Interim Bills as this format only applies to inpatient claims.
- Benefits cannot be provided for an admission if the Member was admitted prior to the effective date of the contract. BlueCare requires split billing for the days the Member’s coverage was actually in effect.
- All inpatient and outpatient electronic (ANSI-837I) and paper (CMS-1450) institutional claims containing one of the following Revenue Codes must contain the appropriate principal procedure code (CPT® or ICD code):

  0360 – 0362 0490-0499
  0367  0710-0720
  0369  0722-0729

- All outpatient CMS-1450 claims must have a CPT®, HCPCS, and Surgical ICD code when surgery procedures are performed. Bilateral surgical procedures must be filed as a single item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported. (See Bilateral Procedures this section for exceptions to this rule.)
N. Dental Services Provided By DentaQuest

(See Section XVIII. CoverKids in this Manual for covered dental services for CoverKids.)

The Division of TennCare and DentaQuest entered into an arrangement where DentaQuest administers and manages dental services for all TennCare Members under age 21 for all Managed Care Organizations. Administration changes include, but are not limited to:

- DentaQuest distributes its own Dental Provider Directory.
- DentaQuest handles all customer service.
- DentaQuest processes all claims.

If you have any questions or need additional information, please call DentaQuest Customer Service at 1-855-418-1623.

O. Vision Services

(See Section XVIII. CoverKids in this Manual for covered vision services for CoverKids.)

Benefits are provided for covered vision care performed, or ordered, or furnished by a duly licensed Physician, Optometrist, Therapeutic Optometrist or Ophthalmologist in connection with the vision care of a BlueCare Member.

All BlueCare Members are eligible for vision benefits when services are for the treatment of an illness or injury to the eye(s). Routine eye exams and glasses are available for each BlueCare Enrollee under the age of 21 years.

Examples of Covered Services and their limitations include, but are not limited to:

- Routine eye examination and refraction as Medically Necessary;
- Permanent pair of standard frames and lenses as Medically Necessary;
- Dispensing fee for an Ophthalmologist, Optometrist, Therapeutic Optometrist or Optician as Medically Necessary;
- Replacement lens and frames for eyeglasses if original pair are lost or broken as Medically Necessary;
- Replacement dispensing fee for an Ophthalmologist, Optometrist, Therapeutic Optometrist or Optician as Medically Necessary;
- Procedures secondary to “routine exam”, e.g., sensorimotor exam, if a corresponding diagnosis is listed on the claim form;
- Contact cataract lens (requires approval); and
- Contact lenses should be considered eligible for children under the age of 21 and when considered Medically Necessary and Medically Appropriate.

Vision benefits are provided for the following diagnoses or treatment when billed on a CMS-1500 claim form:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Diagnosis</th>
<th>Diagnosis</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ametropia</td>
<td>Hypertrophia</td>
<td>Strabismus</td>
<td>Exotropia</td>
</tr>
<tr>
<td>Astigmatism</td>
<td>Myopia</td>
<td>Error of Refraction</td>
<td>Amblyopia</td>
</tr>
<tr>
<td>Hypermetropia</td>
<td>Presbyopia</td>
<td></td>
<td>Esotropia</td>
</tr>
</tbody>
</table>

When billing for vision services, Physicians should consult the current HCPCS manual or the Ophthalmology section of the CPT® manual for the code that most accurately reflects the service provided.
Examples include, but are not limited to the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits</td>
</tr>
<tr>
<td>92012</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, established patient</td>
</tr>
<tr>
<td>92014</td>
<td>Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits</td>
</tr>
<tr>
<td>92340</td>
<td>Fitting of spectacles, except for aphakia; monofocal</td>
</tr>
<tr>
<td>92341</td>
<td>Fitting of spectacles, except for aphakia; bifocal</td>
</tr>
<tr>
<td>92342</td>
<td>Fitting of spectacles, except for aphakia; multifocal, other than bifocal</td>
</tr>
<tr>
<td>92370</td>
<td>Repair and refitting spectacles, except for aphakia</td>
</tr>
<tr>
<td>V2020-V2025</td>
<td>Frames</td>
</tr>
<tr>
<td>V2100-V2118, V2199</td>
<td>Lens - single vision</td>
</tr>
<tr>
<td>V2200-V2220, V2299</td>
<td>Lens - bifocals</td>
</tr>
<tr>
<td>V2300-V2320, V2399</td>
<td>Lens - trifocals</td>
</tr>
</tbody>
</table>

According to CPT®, “fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. Presence of physician is not required.”

To bill replacement lens and/or frames, the HCPCS modifier “RP”, which signifies replacement and repair, should be appended to the HCPCS codes for frame and lens to indicate the items were replaced.

**Vision Benefits for Members Age 21 Years and Over**

Members 21 years of age and over are eligible for the following vision services. Bill charges on the CMS-1500 claim form with appropriate CPT® and ICD codes.

- Treatment by a Practitioner of an illness or injury to the eye(s). For example:
  - Aphakia
  - Conjunctivitis
  - Exotropia
  - Injury to or foreign body in eye
  - Vitreous floaters
  - Cataracts
  - Diabetes
  - Glaucoma
  - Muscle imbalance
  - Chalzion
  - Esotropia
  - Hypertrophia
  - Retinal examinations and surgery

- Lenses and frames for specific illnesses including:
  * One pair of temporary lenses, one pair of permanent lenses and one pair of cataract glasses or lenses after cataract surgery is covered per Enrollee, per lifetime. No replacement cataract lenses or frames are covered.
  * Balanced lenses (when billed with aphakic or cataract lenses);
  * Prismatic lenses;
  * Custom eye prostheses and repairs; and
  * Intra-ocular lens implants

**Vision Services Not Covered**

Orthopedic training and eye exercises; Additional charges for special requests, i.e., oversized, tinted, or no-line bifocal lenses.

**Vision Claim Requirements**

- Must include HCPCS code
- Must indicate ICD diagnosis code
- Block 24(K) Unique Physician Identification Number (UPIN) if applicable
P. Pharmacy Benefits Manager (PBM) Program
(Does not apply to CoverKids)

TennCare’s pharmacy program has a single Preferred Drug List (PDL) that is used statewide for all Enrollees eligible for pharmacy benefits. The PDL and the Automatic Exemption List can be accessed from the Division of TennCare website at https://www.tn.gov/tenncare/providers/pharmacy.html. The Automatic Exemption List contains a listing of medications that will not count toward the (5) five prescriptions or (2) two brand limit when obtained through a participating retail pharmacy.

Providers that feel they cannot order a drug on the PDL are urged to seek prior authorization in advance and to take the initiative to seek prior authorization when contacted by a Member or pharmacy regarding denial of a pharmacy service due to system edits. In order to increase compliance with the PDL and maximize supplemental rebates for the state, the TennCare Pharmacy Benefits Manager (PBM) will produce a report identifying the top one hundred prescribers whose prescriptions are frequently written for non-preferred drugs. The PBM will attempt to contact these prescribers and offer PDL assistance and education.

TennCare Pharmacy Telephone numbers (for provider use only)

Drug Prior Approval: Drug Prior Approval Mailing Address:
Phone: 866-434-5524 Attention: Magellan Pharmacy Solutions, Inc.
Fax: 866-434-5523 11013 West Broad Street, Ste 500
1-866-434-5520 Glen Allen, VA 23060

Pharmacy Provider Help Desk:

Pharmacy Billing Guidelines

Services included in the State of Tennessee Division of TennCare’s Pharmacy Benefit Manager (PBM) Program are not billable to or reimbursable by BlueCare Tennessee.

Services included in this program provided by a Home Infusion Therapy Provider when there is no associated per diem, must be billed to the State of Tennessee Division of TennCare’s Pharmacy Benefits Manager (PBM).

These services include, but are not limited to, the following:

- All drugs and biologicals with the exception of:
  - Autologous cultured chondrocyte implants (i.e. HCPCS code J7330)
  - Dermal tissue products (i.e. HCPCS codes J7340, and J7342)
  - Intrauterine contraceptives (i.e. HCPCS codes, J7300, J7303, J7306, S4989)
- Sterile water and sterile saline (i.e. HCPCS codes A4216 and A4217)
- Consistent with TennCare’s Pharmacy Benefit Management (PBM) billing guidelines, BlueCare Tennessee does not allow any Provider to bill diabetic supplies/services as a medical service.
Claims for these services must be submitted to Magellan Pharmacy Solutions. This includes the following:

- Alcohol Pads
- Blood Glucose Meters
- Blood Glucose Test Strips
- Glucose Control Solutions
- Insulin
- Insulin Syringes
- Ketone Testing Strips
- Lancets
- Pen Needles – Syringe Needles

To order diabetic supplies, complete the Prior Authorization Form for Diabetic Supplies located on the Magellan website at

<https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_Diabetic_Supplies.pdf>.

Fax the completed form to Magellan at 1-866-434-5523.

- Dispensing fees related to drugs administered through durable medical equipment nebulizer suction pumps (i.e., HCPCS code E0590)
- Pharmacy compounding and dispensing services* (i.e., HCPCS code S9430)

*Compounding pharmacies must comply with United States Pharmacopeia (USP) Chapter 797, which sets standards for the compounding, transportation, and storage of compounded sterile products (CSP). 1. The Pharmacy Compounding Accreditation Board can verify that the pharmacy is adhering to these standards.


Q. Provider Overpayments

Providers must comply with the Affordable Care Act and TennCare Policy and procedures, including but not limited to, reporting overpayments, the requirement to report Provider-initiated refunds of overpayments to BlueCare Tennessee and TennCare Office of Program Integrity (OPI) and, when it is applicable, return overpayments to BlueCare Tennessee within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal False Claims Act laws.

The Provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded. A sample copy of the BlueCare Remittance Advice can be found on the company website at http://www.bcbst.com/providers/Sample-Copies-of-Remittance-Advices.page.

Mail to: BlueCross BlueShield of Tennessee or BlueCare Tennessee or CoverKids
Receipts Department
1 Cameron Hill Circle
Chattanooga, TN 37402

Note: In the event that a Provider receives an overpayment notification from BlueCare Tennessee, no action is required unless records conflict with the findings. BlueCare Tennessee will recover the overpayment through an offset to the remittance advice within thirty (30) days from the date of the
notification. **Please do not send a check for the overpayment.** Checks received for solicited overpayments will be returned to the payee.

If we are unable to recover the overpayment due to a credit balance on the claim, the process can involve transferring of overpayment dollars from one or more of the following:

- one Provider number and/or NPI to another
- one tax identification number to another involving the same Provider

These manual overpayment recoveries will appear on the last page of the Provider’s remittance advice with a narrative description of “Manual Reduction”.

**Overpayment Notifications**

An overpayment notification is sent on all overpayments that are identified on claims submitted by Physicians, non-participating facilities and par facilities requiring notification.

*The following guidelines apply to Provider recoveries as a result of overpayments:* Requests for reimbursement of overpayment shall be made no later than two (2) years from the end of the year that BlueCare Tennessee paid the claim submitted by the Provider; except in the case of Provider fraud, in which case no time limit shall apply, or in the case of Third Party Liability (TPL) recoveries where the time frame for initiation of recovery will be no greater than nine (9) months from the date of service except in cases where the Provider received payment from both the primary carrier and BlueCare Tennessee. In such cases, BlueCare Tennessee will follow the two (2)-year timeframe stated above.

The following instructs Providers how to read BlueCare Tennessee’s RA transactions when overpayment recovery activity is reflected:

1. **Automatic Overpayment Recoveries**

   - **Auto-recovery adjustment/moneys recovered:** (when full recovery of overpayment is taken from *current* BlueCare Tennessee RAs):
     - If there is a negative amount in the “Net Paid” column on the RA, this indicates an overpayment adjustment has occurred on the Member’s account.
     - For each account that is being adjusted, there will be a second line entry immediately following the adjustment line. This line entry reflects the corrected net amount paid for the claim (adjusted amount subtracted from the original payment).

   **Exception:**
   *If the overpayment was the result of 1) payment made to an incorrect provider, 2) a duplicate payment, 3) a claim billed in error, or 4) payment made on an incorrect Member, the negative adjustment line will indicate the recovery and there will not be a second line entry.*

   - The second line entry has the corrected amounts listed in the “Provider Contractual Adjustment” and “Patient Owes” columns. Please use the corrected amount in these columns to adjust the Member’s account accordingly.

   - The explanation code reflected in the “Note” column indicates the reason for the adjustment.

   - On the last page of the RA, (bottom of page), the columns are totaled, including any negative adjustments listed on the RA. In the “Net Payment” column, the amount listed should equal the amount of payments and adjustments listed in the RA.

   **Note:** *The “Net Payment” column will not always equal the amount of the check when BlueCare Tennessee recovery amounts are carried from one RA to the next.*
Auto-recovery adjustment/credit balance remains (when partial recovery of overpayment is taken resulting in credit balance owed to BlueCare Tennessee)

- On the last page of the RA, (bottom of page), the columns are totaled, including any negative adjustments listed on the RA. A negative amount in the “Net Payment” column indicates there were insufficient funds on the RA to recover all the funds owed to BlueCare Tennessee. In this situation, the credit balance will be forwarded to the next RA and deduction will be made from the total payment due the Provider on that RA.
  **Note:** If there is a negative amount in the “Net Payment” column, no check will be issued. However, the RA detail should be used to post all Member accounts listed on the RA.

- When a credit balance is created, a “Remittance Adjustment History and Payment Information” page will be added to the RA. This section lists any negative balances that have been carried over from any previous RA s. This section also indicates how much of the negative balance was applied to the current RA payment. Any remaining negative balance will continue to be recorded in this section until the negative balance is satisfied.

- The Remittance Adjustment History and Payment Information page reflects the overpayments deducted from the current RA. The dollar value of the overpayments deducted from the current RA will be reflected in the “Currently Applied” field. The dollar amount still owed BlueCare Tennessee to be recovered from future RAs will be reflected in the “Balance Outstanding” field.

- If a Provider wishes to review claim details to see where a negative balance originated, he/she will need to pull previous RAs to find where the overpaid claim(s) were originally adjusted.

2. Posting Negative Adjustments

The information listed on the Remittance Adjustment History and Payment Information page is critical in posting Member accounts. The “Claim #” field lists the claim(s) where the negative balance originated and what claim(s) were applied to satisfy or partially satisfy the negative balance. The “Adjustment Date” field lists the RA date for each individual claim. The “Comments” field lists what line of business that the negative balance originated.

The following grid offers some examples of Explanation (EX) Codes and descriptions detailing reasons for an adjustment:

<table>
<thead>
<tr>
<th>EX Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD4</td>
<td>Disallowed amount prior to Subrogation adjustment</td>
</tr>
<tr>
<td>ADX</td>
<td>Provider information changed- no interest</td>
</tr>
<tr>
<td>CO1</td>
<td>Secondary – other insurance</td>
</tr>
<tr>
<td>MSP</td>
<td>Payment was made on claim for a member with Medicare primary</td>
</tr>
<tr>
<td>YAI</td>
<td>Additional information received</td>
</tr>
<tr>
<td>YBE</td>
<td>Claim billed in error</td>
</tr>
<tr>
<td>YBI</td>
<td>Interim Bill</td>
</tr>
<tr>
<td>YCC</td>
<td>Deductible/Copay/Coin corrected</td>
</tr>
<tr>
<td>YCP</td>
<td>COB adjustment-paid primary</td>
</tr>
<tr>
<td>YCS</td>
<td>Payment secondary to other insurance</td>
</tr>
<tr>
<td>YDD</td>
<td>Duplicate- should have denied</td>
</tr>
<tr>
<td>YDP</td>
<td>Not Duplicate- should have paid</td>
</tr>
<tr>
<td>YEU</td>
<td>Eligibility Updated</td>
</tr>
<tr>
<td>YNI</td>
<td>Paid wrong benefit level</td>
</tr>
<tr>
<td>YSP</td>
<td>Eligible charge denied in error</td>
</tr>
<tr>
<td>YSD</td>
<td>Ineligible charge paid in error</td>
</tr>
<tr>
<td>YUM</td>
<td>Authorization updated</td>
</tr>
<tr>
<td>YWI</td>
<td>Claim paid on wrong ID or wrong patient</td>
</tr>
</tbody>
</table>
R. Electronic Funds Transfer

Beginning January 1, 2015, BlueCare Tennessee began executing the July 2013 electronic claims filing requirement pursuant to the BlueCare Tennessee Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider’s financial institution and increases the speed at which they receive payment.

**Key advantages to receiving payments electronically are:**
- Earlier payments;
- More secure payment process;
- Reduced administrative costs; and
- Less paper storage.

BlueCare Tennessee accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at [https://solutions.caqh.org](https://solutions.caqh.org).

To view/print a copy of your remittance advices, ensure you have access to Availity, BCBST’s secure area on its websites, [www.bcbst.com](http://www.bcbst.com) and [http://bluecare.bcbst.com](http://bluecare.bcbst.com). To register, go to [http://www.Availity.com](http://www.Availity.com) and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

For more information regarding the EFT Program Process, or for assistance with Availity, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail eBusiness_Service@bcbst.com.

**EnrollHub™** is the new name for the CAQH EFT and ERA enrollment tool.
**Phone:** 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
**e-mail:** eftenrollhub@caqh.org
**Website:** [http://www.caqh.org/eft_enrollment.php](http://www.caqh.org/eft_enrollment.php)

**CAQH ProView™** is now the provider data collection tool formerly the Universal Provider Datasource®.
**Phone:** 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
**e-mail:** proview@caqh.org
**Website:** [https://proview.caqh.org](https://proview.caqh.org)

**Note:** Vendor and BlueCross BlueShield of Tennessee/BlueCare Tennessee shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the “Rules”) in the administration of these ACH Credits.
VI. Primary Care Provider (PCP)

(This section does not apply to CoverKids)

Primary care is defined as physical and behavioral health care services, to include preventive, acute, chronic, and transitional services, provided to individual patients up to a level where specialty care would reasonably be expected to provide added value. Primary Care also includes services of the Patient-Centered Medical Home (PCMH), such as management of a panel of patients for improved care and outcomes across the population.

Through regular contact, the PCP is the Practitioner who can understand each patient’s health status and how it is impacted by lifestyle. The PCP is called on to exercise independent clinical judgment on a case-by-case basis, to discuss options with patients, and to sometimes debate clinical decisions against clinical policies of health plans.

A. PCP Responsibilities

PCPs are responsible for the overall health care of BlueCare and TennCareSelect Members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all Medically Necessary and Covered Services;
- Initiating and/or authorizing referrals for specialty care;
- Monitoring the continuity of Member care services;
- Routine office visits for new and established Members;
- TennCare Kids services;
- Hearing services including: screening test, pure tone audiology, air only audiology, pure tone audiometry and air only audiometry hearing services;
- Counseling and risk intervention, family planning;
- Immunizations;
- Administering and interpreting of health risk assessment instrument;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide Covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy).

B. Primary Care Site/Medical Review Requirements

Specific information related to these reviews may be found in this Manual in Section XVII. Credentialing under Practice Site/Medical Record Standards.
C. PCP Access and Availability

Contractually, BlueCare Tennessee shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional allied, and paramedical personnel for the provision of Covered Services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

*For Primary Care Provider or Physician Extender:*

- Distance/Time between the Practitioner and Member in urban area: 20 miles or 30 minutes;
- Distance/Time between the Practitioner and Member in rural area: 30 miles or 30 minutes
- Member Load: 2,500 or less for Physician; 1,250 or less for Physician Extender;
- Appointment/Waiting Times: Usual and customary practice not to exceed 3 weeks from date of Member’s request for regular appointments and 48 hours for urgent care; and
- Office waiting times should not exceed 45 minutes.

*Note:* Appointments for BlueCare/TennCareSelect Members must reflect local practice and be on the same basis as all other patients served by the Practitioner.
VII. Member Policy

A. Introduction

BlueCare and/or TennCareSelect Members have the right to receive physical and behavioral health care services and have certain responsibilities to aid in receiving them in accordance with the items outlined in this Manual. These responsibilities are designed to protect and enhance the health and well being of the BlueCare and TennCareSelect Member and his or her eligible family members. All Practitioners and professional Providers are encouraged to familiarize themselves with Member rights and responsibilities (referred to as Rights and Duties in the BlueCare or TennCareSelect Member handbooks).

Providers are not permitted to encourage or suggest, in writing or verbally, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term care services covered by TennCare.

B. Member Rights and Responsibilities

Enrollment in BlueCare or TennCareSelect carries with it certain Member rights and responsibilities. While all Members receive a handbook that details those rights and responsibilities (listed below), you should know what our Members are being told to expect from you and what you have the right to expect from those Members. Additionally, BlueCare Tennessee encourages its Members to ask questions and to openly discuss their health care needs with their Provider.

Member Rights

Members have the right to:
- Be treated with respect and dignity, and need for privacy.
- Receive services without discrimination due to age, sex, race, color, religion, and national origin, or any other status protected under federal and state civil rights laws.
- Expect that any information given to any contracted health care Provider or to the Plan will be treated in a confidential manner.
- Receive information about the organization, its services, its Practitioners and Providers and Member rights and responsibilities.
- Receive information regarding Providers in the network.
- Obtain information regarding the structure and operation of the Managed Care Organization (MCO) and Physician incentive plans.
- Receive Medically Necessary and Appropriate medical care.
- Receive information regarding health care and access to medical records as stated in federal and state laws.
- Participate with Providers in decision-making regarding health care.
- Voice grievances about health care Providers, the care received, or the Plan with the expectation of an answer within a reasonable time.
- Appeal formally if the Plan’s answer is not acceptable.
- Receive information on available treatment options and alternatives regardless of cost or benefit coverage, presented in a manner appropriate to the Member’s condition and ability to understand.
- Discuss with health care Providers the Appropriate or Medically Necessary treatment options regardless of cost or benefit coverage.
- Formulate a living will (advance directive).
- Change health plans once during the 45 days after enrollment during managed care organization (MCO) change periods set by the Division of TennCare or after going through an appeal process.
- Choose a PCP within the limits of the Plan, including the right to refuse care from certain Providers.
- Request TennCare reevaluate eligibility decisions.
- Disenroll from TennCare at any time.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, its Providers, or the State agency treat the Member.

Rev 12/17
Member Rights (cont’d)

Members have the right to:

- Make recommendations regarding the organization’s Member rights and responsibilities.
- Make recommendations regarding the organization’s policies and procedures.
- Request medical records be corrected as stated in federal and state laws.
- File a complaint if he/she thinks he/she has been treated unfairly.

Member Responsibilities

Members are expected to:

- Consult the PCP for all non-emergency medical services including referrals for the appropriate services that he/she cannot provide.
- Consult a participating OB/GYN for non-emergency health care during pregnancy without a referral.
- Consult a participating behavioral health provider for non-emergency behavioral health care without a referral.
- To supply information (to the extent possible) that the organization and its Practitioners and Providers need in order to provide care.
- Follow the instructions and advice of health care Providers, or immediately question what is not understood or agreed with.
- Understand their health problems and participate in developing agreed-upon treatment goals, to the degree possible.
- Present identification (ID) card each time when seeking health care.
- Present any other insurance information when seeking health care or a prescription.
- Inform the Tennessee Health Connection if other insurance coverage exists (i.e., health, auto, home or worker compensation, etc.) that will cover medical expenses.
- Ensure ID card usage is for personal services only.
- Notify the Plan and Tennessee Health Connection if there is a change in employment, address or dependents.
- Keep health care appointments; call the health care Provider’s office and/or transportation Provider to cancel if an appointment cannot be kept.
- Treat health care Providers with respect and dignity.
- Pay any applicable copayment or premiums.
- Inform PCP within 24 hours if medical care is received in the Emergency Room.

C. Member Access to Care

To ensure quality and continuity of physical and behavioral health care for BlueCare or TennCareSelect Members after regular clinic hours, Practitioners will provide 24-hours-a-day, 7-days-a-week service. Practitioners must be able to respond to Member calls or calls from an emergency department or hospital concerning their patients within the time limits described in the Member Access and Availability Standards for routine and urgent care.

Arrangements for 24-hour access to equally qualified Practitioners participating in the same BlueCare Tennessee network as the Member’s Practitioner are the responsibility of all contracted Practitioners who participate in BlueCare Tennessee networks.

BlueCare Tennessee will maintain a nurse advice line by calling Customer Service. The appropriate telephone number is listed on the back of the Member’s ID card and is also located in the Member Handbook.

During regular business hours, the Customer Service and Care Management Representatives will assist Members and Providers based on their needs. After-hours, NurseLine will provide to Members the following services:
Standards for telephone access after regular clinic hours:

1. A telephone number or pager answered by covering Practitioner;
2. A non-automated, “live” answering service that directs Members’ calls to an “on-call” covering Practitioner;
3. An automated answering machine that directs the Member to the Practitioner or appropriate covering Practitioner.

Standards for responding to Member telephone calls after regular hours:

1. The Member, or Member’s representative, must be able to speak directly with an appropriate Practitioner;
2. It is acceptable for the answering service to take a message and have the Practitioner return the call to the Member;
3. At a minimum, the live answering service should request the following from the Member:
   - Member Name
   - Name of Treating Practitioner
   - Reason for call
   - Telephone number

Practitioners providing on-call coverage after regular office hours must respond directly to Members or Members’ representative within the following time frames:

- If Urgent, within 30 minutes of receipt of the message from the answering service/machine; or
- If Routine, within 90 minutes of receipt of the message from the answering service/machine.

A survey of compliance with BlueCare Tennessee call coverage policy will be performed during office site visits. Non-compliance shall be addressed through the BlueCross BlueShield of Tennessee Medical Management Corrective Action Plan (See Section XI. Quality Improvement Program in this Manual).

The standards listed on the following grid were designed to provide benchmarks for access regarding BlueCare or TennCare Select Members. BlueCare Tennessee utilizes these guidelines when credentialing and recredentialing Practitioners, OB/GYNs and Specialists.

Specific ambulatory encounters that BlueCare Tennessee will monitor follow:
## Appointment Type

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Definition</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Adult Physical Examination</td>
<td>Routine exam of a patient who has no acute symptoms which includes Medically Necessary and Appropriate health screening and immunizations, if a covered benefit.</td>
<td>≤ 3 weeks</td>
</tr>
<tr>
<td>TennCare Kids</td>
<td>Members less than 21 years old should receive screening examinations according to standards determined by TennCare and set forth by the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. Visit the AAP website at <a href="http://www.aap.org">www.aap.org</a> for recommendations and periodicity schedules. TennCare Kids screenings may include counseling, coordination, and treatment of an anticipatory nature to include guidance and risk reduction interventions, e.g., vaccinations and immunizations.</td>
<td>≤ 3 weeks</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Counseling, diagnosis, treatment and coordination of care for pregnancy for all Members to prevent complications, and decrease the incidence of maternal and prenatal mortality. First trimester Second trimester Second or third trimester</td>
<td>≤ 3 weeks ≤ 15 days</td>
</tr>
<tr>
<td>Urgent Care for Adult and Child</td>
<td>Medically Necessary and Appropriate services and supplies to diagnose and treat acute symptoms of severity that cannot wait until the next available appointment. Facility-based Providers may provide these services.</td>
<td>≤ 48 hours</td>
</tr>
<tr>
<td>Emergency Care for Adult and Child</td>
<td>Medically Necessary services that are required to evaluate, treat, and stabilize a patient’s emergency condition. A condition defined by a “prudent layperson” who possesses an average knowledge of health and medicine, as a medical condition that develops itself by symptoms of sufficient severity, including severe pain. Failure to provide such treatment could place the patient’s health in jeopardy, or cause serious medical consequences, impairment to body functions, or serious or permanent dysfunction of any body organ or part. Facility-based providers may provide these services. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such a determination.</td>
<td>Immediate</td>
</tr>
<tr>
<td>Specialty Care for Adults and Children</td>
<td>Coordination of care, which is diagnostic or confirmatory in nature and needed when an expert is required to perform or determine appropriate follow-up care for a patient. (E.g., cardiology, orthopedics, urology, neurology, hospice care, home health care, rehabilitation services.)</td>
<td>≤ 30 days</td>
</tr>
<tr>
<td>General Optometry Services</td>
<td>Appointment/Waiting Times: Usual and customary not to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting Times shall not exceed 45 minutes.</td>
<td>≤ 3 weeks</td>
</tr>
<tr>
<td>Wait Times</td>
<td>1. Office Wait Time (including lab and X-ray)………………………...&lt; 45 minutes&lt;br&gt;2. Member Telephone Call (during office hours):&lt;br&gt;• Urgent……………………………………………………&lt;br&gt;• Routine……………………………………………………&lt;br&gt;3. Member Telephone Call (after office hours):&lt;br&gt;• Urgent……………………………………………………&lt;br&gt;• Routine……………………………………………………&lt;br&gt;24 Hours&lt;br&gt;2. ≤ 15 minutes&lt;br&gt;2. ≤ 30 minutes&lt;br&gt;2. ≤ 90 minutes</td>
<td></td>
</tr>
</tbody>
</table>

### References:

- Department of Health and Human Services.
- TennCare Contractor Risk Agreement
D. Member/Practitioner Relationship Termination

If a Practitioner has a valid reason he or she cannot establish and/or maintain a professional relationship with a BlueCare or TennCare Select Member, the Practitioner may request to terminate the relationship.

Practitioners requesting to terminate a patient relationship are required to:

1. Mail a certified letter† with return receipt to Member advising:
   - Their relationship is terminating;
   - The reason relationship is terminating; and
   - The Member’s need to obtain new Practitioner.
   †This letter constitutes a thirty (30)-day notice of termination from the date of the letter.

2. Fax a copy of the Member’s certified letter to:
   BlueCare Tennessee PCP Change Team at 1-888-261-9025.

Whether the termination of the Practitioner and Member relationship is initiated by the Practitioner or by BlueCare Tennessee’s termination of the Practitioner, BlueCare Tennessee will send written notification to the Members seen by the Practitioner within the last ninety (90) days of the termination. This letter constitutes the thirty (30)-day notice of termination from the date of the letter.

Note: Until the Member is reassigned, the current Practitioner is responsible for the care. Once a new Practitioner has been assigned, transfer of records to new Practitioner should be done without charge to the Member.

E. Member Appeals– Effective Jan. 1, 2018

IMPORTANT RESPONSIBILITIES:

Notice of Appeal Rights
A written notice shall be given to a Member anytime that adverse action is taken to deny, reduce, suspend or terminate medical assistance. The Notice is provided to the Member by BlueCare Tennessee. The Member has sixty (60) calendar days from receipt of the Notice to appeal the adverse action. Unless contraindicated, the Member may continue to receive services if the Member requests continuation of services within ten (10) calendar days of the Notice and the services have been prescribed by a Provider.

Provider Obligation to Issue Notice of Appeal Rights
The Division of TennCare requires all Members receive appeal rights if there is a reduction, termination, or suspension of 1) any behavioral health service for a Priority Enrollee including enrollees assessed as adults with severely and/or persistent mental illness (SPMI) or children with severe emotional disturbances (SED); 2) any inpatient psychiatric or residential service; 3) any service provided to treat a patient’s chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available; or 4) home health services.

Providers who initiate the reduction, termination or suspension of these services are required to notify BlueCare at least two (2) calendar days before the reduction, termination, or suspension of these services. The Provider Initiated Notice (PIN) form is available at http://bluecare.bcbst.com. Submission instructions are indicated on the PIN form. BlueCare is required to send written notice to the Member at least two (2) business days prior to the reduction, termination or suspension of service.

The Member has the right to continuation of services if the Member requests continuation of services within the two-day notification period prior to the reduction, termination or suspension of service.
The Division of TennCare has developed a two (2)-business day notice letter template for use in notifying patients of any reduction, termination or suspension of service, which falls into the above listed categories. In order to maintain compliance with the above requirements, BlueCare Tennessee will use this form when communicating to BlueCare and TennCare Select Members. A copy of this template is found on the following pages of this Manual and on the TennCare website.

2) When a Provider denies a request for a non-pharmacy service because a Member has exceeded the applicable benefit limit, a Notice that sets forth the reason for the denial shall be issued by the Provider to the Member. The Notice is only required to be issued the first time the service is denied because the applicable benefit limit has been exceeded.

In the event that a Member appeals an adverse action, the reviewing authority will consider only the factual reasons and legal authorities cited in the original notice or corrected notice issued before the notice of hearing. If the MCO’s reasons or legal authorities are not sufficient to support the proposed action, the proposed action must be overruled and the disputed service must be provided. If the TennCare Enrollee is a BlueCare or TennCare Select Member, a copy of the notice with all of the required elements listed above must be mailed or faxed to BlueCare or TennCare Select.

Mail to: BlueCare/TennCare Select Appeals or Fax to: 1-888-357-1916
1 Cameron Hill Circle
Chattanooga, TN 37402

The following guidelines pertain to Provider involvement in the process of Member appeals:

1. Providers should first encourage Members to call the BlueCare or TennCare Select Customer Service line reflected on the back of the Member ID card to discuss concerns/issues.

2. Members may file an appeal for any reason including delays, denials, reduction, suspension or termination of services.

3. If the Member requests to submit the concern as an appeal, he/she should be informed about the appeal form, but also told he/she may submit an appeal on any written signed paper or by calling the TennCare Solutions Unit at 1-800-878-3192. You shall assist the Member with his/her appeal.

4. The appeal request is to be requested within sixty (60) calendar days of the date on the care denial letter and sent to the TennCare central registry.

5. The Member's appeal is then forwarded to the Member’s MCO by TennCare Solutions Unit.

6. For an appeal that involves termination, reduction, delay or denial of service prescribed by the Member’s PCP or referred Provider, the MCO reassesses the case. A letter of result is sent to the Member affirming decision or reversing decision, with a copy to TennCare Solutions Unit within fourteen (14) calendar days of the MCO receiving the appeal for standard appeals or within seventy-two (72) hours for expedite appeals.

6-A. If the MCO reverses its original decision, the requested services are to be rendered.

6-B. If the MCO affirms its original decision and the TennCare Solutions Unit reviews and concurs with the MCO’s original decision, then a hearing is scheduled as deemed necessary by the State to be heard before the Administrative Law Judge with representation from the state. The Member can cancel the hearing at anytime if he/she so wishes.

6-C. If the MCO affirms its original decision and the Division of TennCare reverses the decision, the requested services are to be rendered.

6-D. If the Member appeals and requests continuation of services within ten (10) days of the receipt of notice of action to terminate, suspend or reduce ongoing services and the Member has a Physician’s order for the services, the MCO shall continue to provide the services pending a resolution of the appeal. If the appeal
is decided in favor of the member, the MCO is responsible for the benefits. If the appeal is decided against the Member, the Member may be responsible for the benefits.

7. The Administrative Law Judge will issue a decision based on all documentation/testimony submitted during the hearing.

The treating Provider may submit a Treating Provider’s Certificate; Expedited TennCare Appeal form at any time during the appeals process. This form is located at: https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html. Please fax this completed form and any accompanying documentation to the Division of TennCare at 866-211-7228. (NOTICE: If your patient has already requested this expedited appeal from TennCare, please submit this certificate and documentation as soon as possible.) Expedited appeals must be addressed immediately upon request from the Member. An expedited appeal is an administrative appeal for a medical service that must be either approved or denied within one (1) week, as opposed to up to ninety (90) days, because of the patient’s health. An appeal will only be expedited if waiting up to ninety (90) days for a decision, "could seriously jeopardize the enrollee’s life, physical health, or mental health or their ability to attain, regain, or maintain full function."

Standard appeals must be addressed immediately upon request from the Member. To help ensure appeals are timely, the completed form and/or pertinent medical records should be faxed to BlueCare or TennCareSelect Member Appeals at 1-866-472-6919. If required, a representative from BlueCare Tennessee may contact the Provider office to request copies of pertinent medical records.

**Member appeals to BlueCare/TennCareSelect should be submitted to the following address:**

TennCare Solutions  
P.O. Box 593  
Nashville, TN 37202-0593

**Note:** The Division of TennCare requires that Member appeal forms be available at each service site. Please make the form available for your BlueCare and TennCareSelect patients. If you need additional medical appeal forms, call the TennCare Solutions Unit at 1-800-878-3192. Please note that this form is for use in filing medical and pharmacy appeals ONLY.

**CONTINUING RESPONSIBILITIES:**

If you need the appeal forms and do not have Internet access, call Tennessee Health Connection at 1-855-259-0701.

- Use the appeal form and continue to have these forms available to Members
- Continue to follow BlueCare Tennessee’s requirements regarding prior authorization and out-of-network referrals as outlined in this Manual
- Promptly respond to requests for additional medical information
- Continue to utilize formulary drugs

**Discrimination Complaints**

As stipulated in Section XII, Subsection C of this Manual, Providers must agree to cooperate with TennCare and the MCO during discrimination complaint investigations. Furthermore, Providers must assist TennCare Members in obtaining complaint forms and MCO contact information.

All complaints alleging discrimination on the part of a Provider should be reported to BlueCare/TennCareSelect at the numbers listed below. Members requiring assistance in filing a complaint should be referred to BlueCare/TennCareSelect at the appropriate number listed below:

**BlueCare**
Member Services 1-800-468-9698  
Provider Services 1-800-468-9736

**TennCareSelect**
Member Services 1-800-263-5479  
Provider Services 1-800-276-1978

Complaint forms are available in English, Spanish, and Arabic and can be obtained using the following links:
F. Financial Responsibility for the Cost of Services

If a BlueCare or TennCare Select Network Provider renders a service which is non-covered under the TennCare program, or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, prior to the service(s) being rendered, acknowledging that the Member understands he/she will be responsible for the cost of the specific service(s) and any related services. It is essential the signed statement be kept on file.

Financial responsibility statements

In order for a Provider to document that he properly informed Member that a service is "non-covered," he may choose to use a financial responsibility statement. Financial responsibility statements must be written at no higher than a 6th grade level, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The statement must be signed by the Member. There must be two copies; One (1) retained by the Provider and one (1) given to the Member. There are two (2) situations in which financial responsibility statements are not appropriate:

1. When the Provider is asking the TennCare Member to be responsible for payment if the Provider's claim to the MCO is denied; and
2. When the Provider participates in TennCare but not the Member's MCO (i.e., he is an "out-of-network Provider" for that Member, as that term is defined in the "Applicability" section of TennCare policy, PRO 08-001 (Rev. 9), and the service the Member is seeking is available to him through his MCO.

According to the above TennCare policy, a service may be non-covered for one (1) of three (3) reasons:

1. It is excluded from TennCare coverage. Specific "exclusions" are listed in Rules 1200-13-.10 and 1200-13-14-.10;
2. It would be Covered by TennCare, but it exceeds a benefit limit. As an example, a 6th prescription in a month would be a non-covered service for a Member who is subject to a 5-prescription per month benefit limit on prescription drugs. Where possible, pharmacists are encouraged to count the most expensive prescriptions within the 5-prescription limit and bill the Member for the least expensive prescriptions; and
3. It would be Covered by TennCare with prior authorization, but TennCare or one of its MCOs has denied a request for prior authorization because the service is not Medically Necessary. When a Provider has documentation that TennCare or one of its MCOs has denied a request for prior authorization because the service is not Medically Necessary, the Provider may bill the Member or the Member's family if he has informed them prior to delivering the service that it will not be Covered by TennCare and they have agreed to pay.

To review the entire TennCare policy applicable to this topic, please visit the TennCare website at https://www.tn.gov/content/dam/tn/tenncare/documents2/pro08001.pdf.
XII. Utilization Management Program

A. Program Overview

(See Section XVIII. CoverKids regarding specifics for CoverKids Medical Management.)

The BlueCare Tennessee Utilization Management (UM) Program is intended to assure the provision of appropriate health care to all BlueCare, TennCareSelect, CHOICES, and ECF CHOICES Members in the most cost-effective manner. Achievement of this goal is attained via joint decisions between the Primary Care Provider (PCP), other rendering Provider (if applicable), BlueCare, TennCareSelect, CHOICES, and ECF CHOICES.

The Division of TennCare has adopted a contractual definition of Medical Necessity to be used in determinations of coverage for specific services in individual cases. BlueCare, TennCareSelect, CHOICES, and ECF CHOICES cover Medically Necessary healthcare services not otherwise excluded under the TennCare Program.

Medically Necessary or Medical Necessity (as defined by the Division of TennCare):
Services or supplies provided by an Institution, Physician, or other Providers that are required to identify or treat a TennCare Enrollee’s illness, disease, or injury and are:

1. recommended by a licensed Physician who is treating the Member or other licensed health care Provider practicing with the scope of his or her license who is treating the Member;
2. required in order to diagnose or treat a Member’s medical or behavioral condition;
3. safe and effective;
4. not experimental or investigative; and
5. the least costly alternative course of diagnosis or treatment adequate for the Member’s medical condition.

BlueCare Tennessee covers Medically Necessary and Medically Appropriate health care services not otherwise excluded under BlueCare Tennessee health care benefits plans.

- UM decision making is based only on appropriateness of care and service, and Member eligibility;
- BlueCare Tennessee does not specifically reward Practitioners or other individuals for issuing denials of coverage or service care;
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

BlueCare Tennessee is required by Contract to use appropriately licensed professionals to supervise all Medical Necessity decisions and specify the type of personnel responsible for each level of utilization management decision-making. BlueCare Tennessee must have written procedures documenting access to Board Certified Consultants to assist in making Medical Necessity determinations.

BlueCare Tennessee encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

Behavioral Health

BlueCare, TennCareSelect, CHOICES, and ECF CHOICES Members receive behavioral health services that are fully integrated into our medical health care programs. Our Utilization Management and Population Health programs work together closely to coordinate the delivery of physical health, behavioral health, and social services.

The cornerstone of our model is the Care Team, charged with providing holistic care tailored to each Member’s unique needs. Lead by the PCP, the Care Team comprises individuals responsible for the Member’s care, including Providers, caregivers, state and community organization staff, and BlueCare Tennessee’s Care Facilitators. The composition of the Care Team may change over time, or may be
permanent for a Member with a chronic physical or behavioral health condition. BlueCare Tennessee expects behavioral health Providers to be active partners of this Member’s Care Team, ensuring that Member’s needs continue to be met over time.

PCPs may treat or manage a Member’s behavioral condition within their scope of practice. PCPs are encouraged to call our toll-free primary care Provider consultation line, 1-800-367-3403, Monday through Friday from 9 a.m. to 5 p.m. (ET), to discuss any aspect of treatment for mental substance use disorders, including medications. Board Certified Psychiatrists are available for consultation through this line. PCPs or their staff may also request assistance with referrals for behavioral health services for their patients by calling the consultation line.

Behavioral Health Services provided by an Institution, Physician, or other Providers that are required to identify or treat a TennCare Enrollee’s illness or disease should be ordered/recommended by a licensed Physician or other licensed healthcare Provider practicing with the scope of his or her license who is treating the Member. The order/recommendation may be found in various locations in the record, such as a referral from the higher level of care, in the recommendations on the intake, or on the treatment plan as applicable for the service.

Covered Services include medical evaluations provided by a neurologist, as approved by BlueCare Tennessee, and/or an emergency room Provider that result in a primary behavioral health diagnosis. Claims for behavioral health Covered Services must be filed with the appropriate behavioral health ICD diagnosis code and CPT® procedure code.

BlueCare Tennessee Utilization Management is handled through dual processes called notification and prior authorization. The requirements for both are listed in detail below.

### B. How to Submit Prior Authorization and Notification Requests

Prior Authorization or Notification requests can be submitted in four ways:

1. **Website**
   
   To access e-Health Services, click on the Availity section on the company websites, [www.bcbst.com](http://www.bcbst.com) or [http://bluecare.bcbst.com](http://bluecare.bcbst.com). This service is available twenty-four (24)-hours-a-day, 7-days-a-week for all registered Providers. If you have not registered, go to [http://www.Availity.com](http://www.Availity.com) and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

   This service allows you to submit requests to BlueCare Tennessee online in a real-time Web-secured environment. If the notification/prior authorization request meets specific criteria, you will receive an online approval and reference number. Your request is recorded in our system when it is received.

   **Note:** NICU admissions cannot be submitted via e-Health Services® Web Submission unless submitted with the baby’s personal identification number. Requests for NICU admissions may also be faxed to 423-535-1861. The NICU authorization can be obtained under the mother’s ID number for the first thirty (30) days. However, when requesting the authorization, you must use the baby’s name or a reference that the request is for the baby (i.e., baby girl/boy). Failure to obtain authorization may result in claim denial.

2. **Phone**
   
   Prior authorization or Notification Requests may be called in Monday through Friday, 8 a.m. to 6 p.m. (ET)

   **Medical and Behavioral Health**
   
   BlueCare: 1-888-423-0131
   TennCare Select: 1-800-711-4104
   CHOICES/ECF CHOICES: 1-888-747-8955
   SelectCommunity: 1-800-292-8196
3. Facsimile
Prior Authorizations or Notification requests may be faxed to:

**Medical**

BlueCare or TennCareSelect
East and Middle Grand Region  1-800-292-5311
West Grand Region  1-800-919-9213
Durable Medical Equipment  1-800-292-5311
All Home Health  1-865-588-4663 or 1-423-535-5254
CHOICES/ECF CHOICES  1-800-357-0453
SelectCommunity  1-888-255-9175

**Behavioral Health**

BlueCare
East, Middle, West Grand Region  1-800-292-5311
Provider Initiated Notice  1-800-859-2922

TennCareSelect (Statewide)  1-800-292-5311
Provider Initiated Notice (Statewide)  1-800-859-2922

4. Mail
Prior Authorization or Notification Requests may be mailed to:

BlueCare, TennCareSelect, CHOICES, or ECF CHOICES (specify)
Attn: UM Support CH 4.3
1 Cameron Hill Circle
Chattanooga, TN 37402

**Note:** For In-network Advanced Imaging Prior Authorization requests for BlueCare Tennessee Members, call eviCore at 1-888-693-3211 or fax to 1-888-693-3210.

**Missed Visits Reminder:**

Authorizations will not be adjusted due to missed visits. If all authorized hours are not worked during the week a Member is to receive them, you must follow protocol for claim payment adjustments; as this is not an authorization adjustment.

Please send this information on the missed visit form located on the Provider portal on the BlueCare website at [https://bluecare.bcbst.com/providers/forms.html](https://bluecare.bcbst.com/providers/forms.html).

Effective 1/1/2019, a Universal Managed Care Organization (MCO) Missed Visit Form has been approved by the Division of TennCare for use by all MCOs. When there is a missed visit or future missed visit of one or more hours, report the information by calling or faxing BlueCare, TennCareSelect, or CHOICES/ECF CHOICES at the appropriate number below:

BlueCare
Phone: 1-888-423-0131  Fax: 423-535-1931

TennCareSelect
Phone: 1-800-711-4104  Fax: 1-888-744-7587

CHOICES/ECF CHOICES
Phone 1-888-747-8955
The following grid is intended to assist you in determining the appropriate contact/method according to type of service requested.

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<thead>
<tr>
<th>Type of Service</th>
<th>Contact</th>
<th>Submit via:</th>
</tr>
</thead>
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<tr>
<td>Transplant Requests</td>
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<td>Phone/Fax</td>
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<tr>
<td>Durable Medical Equipment (DME)</td>
<td>BlueCare Tennessee</td>
<td>Online/Phone/Fax</td>
</tr>
<tr>
<td>Home Health and Private Duty Nursing Services</td>
<td>BlueCare Tennessee</td>
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</tr>
<tr>
<td>In-network Advanced Imaging for BlueCare Members Only</td>
<td>eviCore</td>
<td>Online/Phone/Fax</td>
</tr>
<tr>
<td>Hospice (Notification)</td>
<td>BlueCare Tennessee</td>
<td>Online/Phone/Fax</td>
</tr>
<tr>
<td>Skilled Nursing Facilities (SNF)/Rehab/Long Term Acute Care (LTAC)</td>
<td>BlueCare Tennessee</td>
<td>Phone/Fax</td>
</tr>
<tr>
<td>NICU admissions, updates, and concurrent reviews</td>
<td>BlueCare Tennessee</td>
<td>Online/Phone/Fax</td>
</tr>
<tr>
<td>Outpatient Therapies</td>
<td></td>
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<tr>
<td>Out-of-Network Services</td>
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<td>Chiropractic Services</td>
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<tr>
<td>Diagnostic Testing/Labs</td>
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<td>Home Infusion Therapies</td>
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<td>Maternity Care Management Notification</td>
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<td>Inpatient Services</td>
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<tr>
<td>Behavioral Health Requests</td>
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<tr>
<td>Special kids</td>
<td>BlueCare Tennessee</td>
<td>Fax</td>
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<tr>
<td>Brown Center for Autism</td>
<td>BlueCare Tennessee</td>
<td>Fax</td>
</tr>
<tr>
<td>Specialty Pharmacy Medications</td>
<td>BlueCare Tennessee</td>
<td>Online/Phone</td>
</tr>
</tbody>
</table>

**C. Services Requiring Notification**

Requests for notification are not subject to prospective Medical Necessity Review, but may be subject to retrospective review based on Medical Criteria.

The following services require **notification** for BlueCare, TennCare Select, CHOICES, or ECF CHOICES:

- Hospice - submit on Hospice Request form*.
- Twelve (12) initial Outpatient Physical Therapy (PT) Visits, Outpatient Occupational Therapy (OT) Visits and/or Outpatient Speech Therapy (ST) Visits (Age 21 and older). Notification required prior to therapy being rendered. Notification is not required for Members less than 21 years of age. Submit on Therapy Request form*.
- Any order/requests for services more than twelve (12) outpatient PT/OT/ST visits will require all necessary clinical be submitted for Medical Necessity review for the service or the medical need for original service. Or, similar diagnosis or limb will require a Medical Necessity review for the services requested.
All notification requests must include the following information. This information is necessary for accurate claims processing and payment. Some requirements are necessary in order to meet the notification process under TennCare. All notification services are screened for non-covered, excluded, out-of-network, investigational procedures as well as any abortion, sterilization, or hysterectomy procedures.

- Member Name
- Member ID Number
- Dates of Service
- Number of visits Requested
- Provider ID Number (NPI)
- Ordering MD Name
- MD Order for Service

D. Services Requiring Prior Authorization

The following services require Prior Authorization:

- All non-covered, Investigational or cosmetic procedures or services
- All out-of-network services (hospital or professional)
- All transplants
- All Inpatient hospital admissions (Discharge information should be sent daily to BlueCare Tennessee to help ensure appropriate member follow up and coordination of care. Discharge dates may be entered via the web (for individual case entries), faxed to (423) 591-9501, called in toll-free to 1-855-339-9781, or e-mailed to dcdates@bcbst.com for all lines of business. If faxing, providers may submit one list with all Member names as long as the appropriate line of business to which the Member belongs is indicated. Provider cover sheets should include the facility name and NPI number to ensure appropriate and efficient processing.)

- Cosmetic Surgery

Cosmetic Surgery is not covered under the terms of the TennCare Contract. However, reconstructive surgery may be covered based on Medical Necessity. Breast Reconstruction and surgery for symmetry following a mastectomy is a covered service.

  - Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.
  - Surgery on the non-diseased breast, to establish symmetry between the two breasts in the manner chosen by the Member and the Practitioner is considered Medically Necessary.

  **Note:** The surgical procedure performed on the non-diseased breast will only be covered if the surgery on the non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on the diseased breast.

- Out-Of-Network Services

Requests for non-emergency out-of-network office visits, treatments and/or services require prior authorization and are considered on an individual case basis. Providers must explain the Medical Necessity of a BlueCare, TennCareSelect, CHOICES, or ECF CHOICES Member receiving services outside the BlueCare, TennCareSelect, CHOICES, or ECF CHOICES networks. Individual consideration is given and benefits are limited.

Emergency out-of-network services (based on diagnosis filed on claim) are covered. BlueCare Tennessee may need to assist the Provider in returning the Member to the network when it is medically safe.

- Transplant Services

All transplant evaluations require notification. All organ transplants require prior authorization. It is critically important, to both the Provider and Member, that BlueCare Tennessee Transplant Case Management Department be contacted as soon as the Member has completed the evaluation and
Practitioner has deemed him/her as an appropriate candidate to be listed for transplant. Providers should contact BlueCare Tennessee to verify participating facilities in the Transplant Network before referring Members for transplant evaluation or services, which could result in a transplant (e.g., high-dose chemotherapy). To initiate transplant notification/authorization, call BlueCare Tennessee at 1-800-225-8698, and press “1” for BlueCare, TennCareSelect, CHOICES, or ECF CHOICES.

Note: BlueCare Tennessee does not cover Hair transplants.

The following Organ Transplants require prior authorization:

- Bone Marrow
- Heart
- Kidney
- Kidney-Pancreas
- Hematopoietic Stem Cell
- Lung
- Heart-Lung
- Small Bowel/Multi-Visceral
- Progenitor Stem Cell
- Pancreas
- Liver
- CAR-T Therapy

*Prior authorization for these services should be submitted utilizing the Transplant Request form located on BlueCare Tennessee website at https://bluecare.bcbst.com/providers/forms.html.

E. Outpatient Services Requiring Prior Authorization

The following outpatient services/procedures require prior authorization

- Arthroscopy
- Endoscopy
- Laparoscopic Cholecystectomy
- Nerve Conduction Studies
- Epidural Steroid Injections
- All services performed by a plastic specialist, including but not limited to:
  - Abdominopasty/Panniculectomy
  - Blepharoplasty
  - Breast Reduction
  - Reconstructive Repair Pectus Excavatum
  - Vein Ligation
- Chiropractic Services Medically Necessary for Children (under age 21 years)
  Note: Chiropractic services for age 21 years and older are non-covered unless determined to be a cost effective alternative.
- All Outpatient Therapies (21 years and older)** (excludes evaluations and initial twelve (12) PT/OT/ST visits) submit on Therapy request form located on BlueCare Tennessee website at https://bluecare.bcbst.com/providers/forms.html.
  - Physical Therapy for age 21 years and older is covered, as Medically Necessary, when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions. See previous section for services requiring notification for Physical Therapy.
  - Speech Therapy for age 21 years old and older is covered, as Medically Necessary, when provided by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic, or personality disorder.
  - Occupational Therapy for age 21 years and older is covered, as Medically Necessary, when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions.
- All Hyperbaric Oxygen therapy
- All Bariatric Surgeries

**Prior Authorization is not required for outpatient physical, occupational, or speech therapy evaluations only. However, prior authorization for therapy services is required for adults.

Note: Prior Authorization is not required for TennCare Kids screenings when performed by a participating Provider.
F. Specialty Pharmacy Prior Authorization Requirements

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient require prior authorization for all lines of business. This authorization requirement applies to all Provider types including home infusion therapy Providers and hospitals providing outpatient infusions and injections.

Providers who choose to bill BlueCare Tennessee directly for these medications rather than utilizing a pharmacy vendor must obtain prior authorization from BlueCare Tennessee before administering and billing the drug.

Home Infusion Therapy Providers billing for the drug only or pharmacies with a National Council for Prescription Drug Programs (NCPDP) number must contact and bill Magellan Pharmacy Solutions, the Division of TennCare’s pharmacy benefits manager at:

Phone 1-866-434-5524
Fax 1-866-434-5523

All other Providers should call:
BlueCare 1-888-423-0131
TennCare Select 1-800-711-4104
CHOICES/ECF CHOICES 1-888-747-8955

Note: New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed on the company website at http://www.bcbst.com/providers/newsletters/index.page. The pharmacology section of the BlueCross Medical Policy Manual includes decision support trees to assist Providers considering use of these medications. Providers can select the appropriate drug from the manual at http://www.bcbst.com/MPManual/Pharmacology.htm and connect to the decision support tree in the policy.

The following information is required when requesting prior authorization for specialty drugs:

- Practitioner’s Order
- HCPCS (code J, Q, or S)
- Drug name
- National Drug Code (NDC)
- Frequency
- Dosage
- Member-specific Clinical information to support the request

These drugs are currently assigned specific HCPCS codes. Claims should be submitted with specific code for the drug. Claims should only be submitted with a miscellaneous HCPCS code when no specific code exists. When a miscellaneous code is used, the following supplemental information is also required:

- Practitioner’s order
- Drug name
- Dosage
- Amount supplied
- Valid NDC number

A complete listing of BlueCare specialty pharmacy medications can be viewed online at http://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf.

- Home Infusion Therapy (HIT)

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the
Member’s **private residence**. A request for HIT originates with a prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

Prior authorization is required for:

- Out-of-Network Total Parenteral Nutrition (TPN); and
- Out-of-Network Per Diems.
- Specialty Pharmacy Drugs (when drug is billed with per diem)

When billing BlueCare, TennCareSelect, CHOICES, or ECF CHOICES for specialty drugs, HIT Providers must obtain prior authorization.

HIT Providers should continue to file claims with Magellan Pharmacy Solutions when **only** billing for drugs and biologicals when no infusion services are provided. In these cases, HIT Providers should adhere to Magellan Pharmacy Solutions prior authorization requirements. Drugs, which cannot be self-administered, should be billed as a medical benefit by the administering Provider.

### G. Advanced Imaging Prior Authorization Requirements

Advanced imaging services include:
- CT
- PET
- MRI
- MRA

Contact eviCore at 1-888-693-3211 and via fax at 1-888-693-3210 to arrange Prior Authorizations for BlueCare Members.

For TennCareSelect Members, no authorization is required for in-network providers. For out-of-network, call BlueCare Tennessee Utilization Management department at 1-800-711-4104. (A complete listing of advanced imaging codes can be found on the company website at [www.bcbst.com/providers/hti](http://www.bcbst.com/providers/hti)).

### H. Durable Medical Equipment (DME), Orthotic and Prosthetic (O&P), Medical Supply Prior Authorization Requirements

Durable Medical Equipment (DME) means equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, is suitable for use in any non-institutional setting in which everyday life activities take place, and is related to the Member’s physical disorder. Orthotics, prosthetic devices, artificial limbs and artificial eyes are considered DME. Non-institutional settings exclude hospitals and nursing facilities (NF).

Routine DME items, including but not limited to wheelchairs (except as defined below), walkers, hospital beds, canes, commodes, traction equipment, suction machines, patient lifts, weight scales, and other items provided to a Member receiving services in a nursing facility that are within the scope of per diem reimbursement for nursing facility services shall not be covered or reimbursable under the Medicaid program separate and apart from payment for the NF service. Customized orthotics, prosthetics, wheelchairs, wheelchair seating systems, and other items that are beyond the scope of Medicaid reimbursement for NF services shall be covered by the Member’s managed care organization, so long as such items:

- are Medically Necessary for the continuous care of a Member; and
- must be custom-made or modified or may be commercially available, but must be individually measured and selected to address the Member’s unique and permanent medical need for positioning, support or mobility; and
- are solely for the use of that Member and not for other nursing facility residents
Prior Authorization is required on all Durable Medical Equipment and medical supplies provided* by a DME Provider unless listed on the no prior authorization required list found on the BlueCare Tennessee website at https://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf.

All Orthotics and Prosthetics and supplies provided or services by an O&P Provider require a prior authorization unless listed on the no prior authorization required list found on the BlueCare Tennessee website at https://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/DME_No_Prior_Auth_Required.pdf.

All DME Repairs serviced or supplied by a DME Provider.

All food supplements and substitutes, including formulas taken by mouth.

An electric breast pump can be provided with a Physician order and by completing the information at http://breastpumpsmedline.com or at http://www.breastpumps.aeroflowinc.com/qualify-through-insurance. 

Retrospective review can be requested, instead of prior authorization for Members with Medicare Primary.

Oxygen and Oxygen Equipment Rental

All incontinence supplies are supplied and managed through Medline. Incontinence diaper supplies >200 per Member per month must be Medically Necessary.

To request prior authorization, call, fax, or e-mail Medline at:

Call (Toll-free) 1-877-853-7558
Fax 1-866-557-2737
e-mail BlueCareTennessee@medline.com

Quantities >200 per month require Medical Necessity review of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4335</td>
<td>Incontinence supply; misc.</td>
<td>T4531</td>
<td>Pediatric, small/medium, pull-on</td>
</tr>
<tr>
<td>A4335SC</td>
<td>Diaper wipes/disposable washcloth (per each -30 units per box)</td>
<td>T4532</td>
<td>Pediatric, large, pull-on</td>
</tr>
<tr>
<td>A4554</td>
<td>Disposable underpads, any size</td>
<td>T4533</td>
<td>Youth, brief/diaper</td>
</tr>
<tr>
<td>T4521</td>
<td>Adult, small, brief/diaper</td>
<td>T4534</td>
<td>Youth, pull-on</td>
</tr>
<tr>
<td>T4522</td>
<td>Adult, medium, brief/diaper</td>
<td>T4535</td>
<td>Liner/shield/guard/pad/undergarment</td>
</tr>
<tr>
<td>T4523</td>
<td>Adult, large, brief/diaper</td>
<td>T4536</td>
<td>Pull-on, reusable, any size</td>
</tr>
<tr>
<td>T4524</td>
<td>Adult, extra-large, brief/diaper</td>
<td>T4537</td>
<td>Protective underpad, reusable, any size</td>
</tr>
<tr>
<td>T4525</td>
<td>Adult, pull-on, small</td>
<td>T4539</td>
<td>Diaper/brief, reusable</td>
</tr>
<tr>
<td>T4526</td>
<td>Adult, pull-on, medium</td>
<td>T4540</td>
<td>Protective underpad, reusable, chair size</td>
</tr>
<tr>
<td>T4527</td>
<td>Adult, pull-on, large</td>
<td>T4541</td>
<td>Disposable underpad, large</td>
</tr>
<tr>
<td>T4528</td>
<td>Adult, pull-on, extra large</td>
<td>T4542</td>
<td>Disposable underpad, small</td>
</tr>
<tr>
<td>T4529</td>
<td>Pediatric, small/medium, brief/diaper</td>
<td>T4543</td>
<td>Brief/Diaper, Bariatric</td>
</tr>
<tr>
<td>T4530</td>
<td>Pediatric, large, brief/diaper</td>
<td>T4544</td>
<td>Adult sized pull up diapers</td>
</tr>
</tbody>
</table>

**I. Inpatient Admission Prior Authorization Requirements**

- All inpatient admissions;
- Neonatal Intensive Care Unit admissions Levels II, III, or IV (Revenue codes 0172, 0173, or 0174); **Note:** Revenue Codes 0170 and 0171 (newborn nursery care) do not require an authorization.
- Inpatient rehabilitation facility services are not covered for adults age 21 years and older unless determined to be cost-effective alternative;
- Skilled Nursing Facility (SNF) non covered unless determined to be cost effective alternative

**Note:** Inpatient admission for pregnant women does not require an authorization.
J. Behavioral Health Prior Authorization Requirements

The following behavioral health services require prior authorization:

- Inpatient Detoxification Crisis Respite
- Subacute Psychiatric Crisis Stabilization (notification only)
- Hospital Partial Home Health
- Substance Use Psychiatric Electroconvulsive Therapy
- Disorder Psychiatric Transcranial Magnetic
- Residential Psychiatric Stimulation
- Treatment Psychiatric Supported Housing
- Psychiatric Psychiatric Electroconvulsive Therapy
- Residential Psychiatric Transcranial Magnetic
- (Rehabilitation) Stimulation

The Division of TennCare requires all Members being discharged from any behavioral healthcare service to be notified of their rights to appeal that discharge decision. Providers are required through the Division of TennCare Notification process to notify the Managed Care Organization (MCO) of any Provider initiated discharge by submitting a “Provider Initiated Notice (PIN)” form two (2) calendar days before the discharge. The MCO is responsible for providing the Member with a letter that outlines his or her appeal rights. An electronic copy of the PIN form is available on the company website, http://bluecare.bcbst.com. (See section XV Behavioral Health Services in this Manual for more information on covered behavioral health services.)

Submit using the appropriate Behavioral Health request form located on BlueCare Tennessee website at https://bluecare.bcbst.com/providers/forms.html.

K. Home Health and Private Duty Nursing Prior Authorization Requirements

All Home Health Skilled Nursing and Aide visits, Home Health Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Hourly nursing and aide services, and Private Duty Nursing require Prior Authorization. Note: Prior authorization is not required for Members less than 21 years of age for Home Health PT, OT, or ST.

The initial twelve (12) Home Health Visits for Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, and Speech Therapy can be administratively approved when requested. Any request for more than the number of visits outlined or extension visits will require full Medical Necessity review.

Based on a State of Tennessee directive, BlueCare Tennessee is required to implement changes to BlueCare/TennCareSelect home health and private duty nursing benefits. TennCare will only cover private duty nursing (PDN) for adult members who:

1. Is ventilator dependent for at least twelve (12) hours each day with an invasive patient end of the circuit (i.e., tracheostomy); or
2. Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least twelve (12) hours each day in order to avoid or delay tracheostomy (requires medical review); or
3. Have a functioning tracheostomy requiring suctioning and need other specified types of nursing.

Members with a functioning tracheostomy must also require all of the following: 1) oxygen, 2) nebulizer or cough assist, 3) medication via G-tube, PICC line or central port and 4) TPN or nutrition via G-tube. For all other adult Members, the following home health coverage limits apply:
Limits for most TennCare Adults:

<table>
<thead>
<tr>
<th>Home Health Aide Care</th>
<th>Home Health Nurse Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 35 hours per week</td>
<td>Up to 27 hours per week</td>
</tr>
<tr>
<td>- No more than 8 hours/day</td>
<td>- No more than 8 hours/day</td>
</tr>
<tr>
<td>- No more than 2 visits/day</td>
<td>- No more than 1 visit/day</td>
</tr>
<tr>
<td>- HH aide and nurse combined cannot exceed 35 hours per week</td>
<td>- HH nurse and aide care combined cannot exceed 35 hours per week</td>
</tr>
</tbody>
</table>

For example, 35 hours =
- 7 hours, 5 days/week
- 5 hours, 7 days/week

For example 27 hours =
- 5 hours, 5 days/week
- 3.5 hours, 7 days/week

Limits for TennCare Adults who need one or more of the skilled or rehabilitative services for Nursing Facility Care noted within TennCare Rule 1200-12-01-.10:

<table>
<thead>
<tr>
<th>Home Health Aide Care</th>
<th>Home Health Nurse Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 40 hours per week combined aide and nurse per week</td>
<td>Up to 30 hours per week</td>
</tr>
<tr>
<td>- No more than 8 hours/day</td>
<td>- No more than 8 hours/day</td>
</tr>
<tr>
<td>- No more than 2 visits/day</td>
<td>- No more than 1 visit/day</td>
</tr>
<tr>
<td>- HH aide and nurse combined cannot exceed 40 hours per week</td>
<td>- HH nurse and aide care combined cannot exceed 40 hours per week</td>
</tr>
</tbody>
</table>

For example, 40 hours =
- 8 hours, 5 days/week
- 5.5 hours, 7 days/week

For example 30 hours =
- 6 hours, 5 days/week
- 4 hours, 7 days/week

Home Health Services shall mean any of the following services ordered by a treating Physician and provided by a licensed Home Health Agency pursuant to a plan of care at an enrollee’s place of residence:

1. Part-time or intermittent nursing visits;
2. Home health aide visits;
3. Hourly skilled nursing services;
4. Hourly home health aide services;
5. Private duty nursing services;
6. Physical therapy, occupational therapy, or speech pathology and audiology services; or
7. Medical Social Work.

Under present law, the Medical Assistance Act requires the provision of medical assistance to eligible persons, including the provision of home health care services. Provision of home health care services under the Act are those services that are provided in the recipient’s home and must follow the recipient into the community for the purposes of providing services during routine activities of daily living such as:

- Outpatient medical appointments
- School and other educational functions
- Employment and volunteer opportunities
- Church and religious services

T.C.A. § 71-5-107(a)(12) authorizes home health nurses and aides to accompany a recipient outside the home during the course of prior approved home health services if all of the following criteria are met:

1. The home health nurse or aide must not transport the service recipient.
2. The home health agency will have discretion as to whether or not to accompany a recipient outside the home.
3. Additional visits or hours of care will not be approved for the purpose of accompanying a recipient outside the home.
4. No additional reimbursement will be paid to the home health agency in association with the decision of the agency to accompany a patient outside the home.
This Act specifies that its provisions are not intended to create an entitlement to services and that a home health agency will not be subject to legal action as a result of exercising its discretion pursuant to this amendment.

Home health Providers may only provide services that have been ordered by the treating Practitioner, are pursuant to a plan of care and may not provide other services such as general child care services, cleaning services, preparation of meals, or services to other household members. To the extent that home services are provided to a person under 18 years of age, a responsible adult (other than the home health Provider) must be present at all times in the home during provision of home health services unless all of the following criteria are met:

1. The child is non-ambulatory; and
2. The child has no or extremely limited ability to interact with caregivers; and
3. The child shall not reasonably be expected to have needs that fall outside the scope of Medically Necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health Provider would be present in the home without the presence of another responsible adult; and
4. No other children shall be present in the home during the time the home health Provider would be present in the home without the presence of another responsible adult.

If a responsible adult is not present, the care must still be provided and BlueCare Tennessee should be notified immediately if this occurs.

Private Duty Nursing (PDN) services are for Members who require continuous skilled nursing care (eight (8) or more hours during a twenty-four (24) hour period) provided by a registered nurse or licensed practical nurse under the direction of the recipient’s Practitioner.

Home health agencies must obtain prior authorization for all home health care visits and hourly services and private duty nursing services. The home health agency is responsible for ensuring that the prior authorization process is completed within designated time frames.

Special Kids provides both therapeutic rehabilitation and professional nursing services at one facility as an opt-in program instead of PDN services. Only Members meeting the following criteria are considered for this program:

- Classified Disabled
- 21 years or younger
- Referred to the Special Kid’s organization by a Physician
- Meet Medical Necessity for Home Health PDN
- TennCareSelect Member

Note: Requests for all Home Health Nursing and aide visits and services, as well as all Private Duty Nursing services for BlueCare and TennCareSelect Members should be submitted via e-Health Services on the company website, http://bluecare.bcbst.com or faxed to 1-423-535-5254. Submit using the Private Duty, Skilled Nurse, Home Health Aide request form located on BlueCare Tennessee website at: https://bluecare.bcbst.com/providers/forms.html.

### L. Medical Review Requirements and Criteria

Medical reviews are reviews of selected interventions and are performed:

- Where evidence suggests safe, effective alternatives exist, or
- Because of mandates from oversight agencies.

BlueCare, TennCareSelect, CHOICES, and ECF CHOICES reviews are based first upon the Division of TennCare Rules. The information submitted must support Medical Necessity as established by the Division of TennCare Services or supplies provided by an Institution, Physician, or other Providers that are required to identify or treat a TennCare Member’s illness, disease, or injury are:
1. recommended by a licensed Physician who is treating the Member or other licensed health care Provider practicing within the scope of his or her license who is treating the Member;
2. required in order to diagnose or treat a Member’s medical or behavioral condition; include the authentication of verbal orders by having the Physician sign prior to calling, faxing, or processing online;
3. safe and effective;
4. not Investigational or Experimental; and
5. the least costly alternative course of diagnosis or treatment adequate for the Member’s medical condition.

BlueCare Tennessee and TennCareSelect reviews requests based on Medical Necessity. The guidelines utilized are applied in the following hierarchy:

- BCBST Medical Policy located https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm;
- MCG adopted guidelines (formerly Milliman Care Guidelines®) by BlueCare Tennessee, and

Review requirements are subject to change. Providers will be notified of any changes in review requirements through bulletins updating this Manual, BlueAlert articles, and other BlueCare, TennCareSelect, CHOICES, or ECF CHOICES communications. All information is subject to verification by review of the Member’s medical record and other sources. Benefits are always subject to eligibility verification by the State of Tennessee, Division of TennCare.

M. Documentation Required

All Prior Authorization Requests should be submitted using the appropriate request form along with required information. Forms are located on the BlueCare Tennessee website at http://bluecare.bcbst.com/providers/forms.html.

Submit the following required information for Home Health Skilled Nursing, Home Health Aide services, Physical Therapy, Occupational Therapy, Speech Therapy visits, Hourly Nursing and Aide services, and Private Duty Nursing Services Prior Authorization Requests.

BlueCare Tennessee will accept verbal, electronic and written orders from the ordering Physician for Home Health Services. Requests must have the following components to be a valid order:

- Services being ordered
- Quantity of services
- Order must be signed and dated
- Order must be signed within the last calendar year, orders greater than 12 months old are not considered to be valid

It is the servicing Provider’s responsibility to ensure they obtain the ordering Physician’s signature and that the signed order is on file.

Electronic signed orders must state, “electronically signed” or “digitally signed” to be considered a valid order.

Examples of a valid verbal order:

John Smith DOB 12.12.17 Private Duty Nursing 112 hours per week for one year
VORB Dr Curtis/Karen Hall, RN 1/1/19

John Smith DOB 12.12.74 12 Home Health Skilled Nurse Visits two times a week for six weeks
VORB Dr. Curtis/Karen Hall, RN 1/1/19

Rev 06/19
BlueCross does not require the actual order. However, it is the responsibility of the agency to have the order on file; as well as submit Member clinical and goals as BlueCare can request the order at any time.

**Note:** Medical records must be legible with all appropriate information pertaining to the presenting case. BlueCare Tennessee may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate. Upon request from BlueCare Tennessee or the Division of TennCare for purposes of making individualized Medical Necessity determinations, the treating Physician or other treating health care Provider must provide information and/or documentation supporting the need for the recommended medical item or service. BlueCare Tennessee will attempt to obtain information telephonically, verbally or via facsimile. Additionally, BlueCare Tennessee may request the treating Physician or other treating health care Provider to provide a written explanation as to why a proposed less costly alternative is not believed to be adequate to address the Member’s medical condition. Information and/or documentation requested for the purpose of making a Medical Necessity determination must be provided free of charge.

**Note:** According to Contract, BlueCare Tennessee will not reimburse for photocopying expenses.

**Home Health Services**

Home health authorizations and notifications are to be submitted via e-Health Services® on the company websites, [www.bcbst.com](http://www.bcbst.com) or [http://bluecare.bcbst.com](http://bluecare.bcbst.com). The home health agency must have an order from the ordering Physician along with the following information:

- Name of Practitioner prescribing the service(s) with a signed and dated MD order. If the signature is electronic, it must state electronically signed by the Practitioner’s name and must also be dated;
- Specific information regarding the patient’s medical condition and any associated disability that creates the need for the requested service(s);
- Type of service requested to include CPT®/HCPC Code;
- Specific information regarding the service(s) the nurse or aide is expected to perform including amount and frequency with which each service must be performed (e.g., tube feeding patient, bathing, administering medications, catheterizations, wound dressing);
- Total time period the services are anticipated to be Medically Necessary by the treating Practitioner to include a start and end date of services; and
- Nursing notes for private duty nursing and home health services rendered.

**Note:** The Practitioner’s order must provide documentation of the hours of private duty nursing services required and the length of time the services are needed.

**N. Timely Submission of Prior Authorization or Notification Request**

Services rendered without obtaining a prior authorization prior to services being rendered are considered non-compliant. Although it is always in the Provider’s best interest to receive authorization prior to rendering a service, please see the non-compliance guidelines below for specific service types:

- **Elective (Scheduled) Inpatient admission**
  Authorization is required prior to Member’s admission.
- **Emergency Inpatient admission**
  Authorization is required within twenty-four (24) hours or the next business day.
- **Inpatient conversion**
  Authorization is required within twenty-four (24) hours or the next business day from admission date.
- **Durable Medical Equipment (DME) and Orthotics and Prosthetics (O&P)**
  Authorization is required within seventy-two (72) hours or next business day from services being provided to the Member unless Member has Medicare Primary coverage. If Medicare is Primary, retrospective review can be obtained.
- **Outpatient Services**
  Authorization is required prior to services being rendered.
- **Home Health**
  Authorization is required prior to services being rendered.
Failure to comply within specified notification/prior authorization timeframes may result in a denial due to non-compliance. The Member cannot be billed for services denied due to non-compliance by the Provider and a notification/prior authorization denied due to non-compliance cannot be appealed unless:

- The Member did not provide BlueCare Tennessee insurance information
- The Member ID Card was not issued
- Medicare was incorrectly documented as primary
- There was a coverage issue

Note: An exception to the above can be made if retro-eligibility occurs and the Provider was unaware that the Member had BlueCare or TennCareSelect.

O. Prior Authorization Process

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. However, it is ultimately the facility and Practitioner’s responsibility to contact BlueCare Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.

A Prior Authorization may be retroactively denied by BlueCare Tennessee if BlueCare Tennessee subsequently determines that 1) the health care services rendered were not included as Covered Services under the applicable Benefit Plan; 2) such services were not Medically Necessary; 3) the Member was ineligible for such services at the time the services were rendered; or 4) the information submitted with the Prior Authorization request was not accurate and complete.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering care for the day(s) or service(s) that have been denied. BlueCare Tennessee’s non-payment is applicable to both facility and Practitioner rendering care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider. Requests for Prior Authorization are initially reviewed by Nurse Clinicians or Utilization Management Licensed Practical Nurses using approved clinical criteria. If the Nurse Review cannot approve the request, it is submitted to the BlueCare Tennessee Medical Director for additional review.

If the BlueCare Tennessee Physician reviewer feels that the request for authorization cannot be approved, a verbal notification of the denial will be made to the requesting Provider as well as a denial letter being mailed to the Member, ordering, and requesting Providers. The requesting Provider may appeal the decision (See Appeals section later in this section for additional information.)

Standard Authorization Decisions:
BlueCare Tennessee will provide notice as expeditiously as the Member’s condition requests and within State-established timeframes that may not exceed fourteen (14) calendar days following the receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

1. The Member or Provider requests extension; or
2. BlueCare Tennessee justifies (to the State agency upon request) a need for additional information and how the extension is in the Member’s interest.

Expedited Authorization Decisions:
For cases in which a Provider indicates, or BlueCare Tennessee determines that the Standard timeframe could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function, BlueCare Tennessee must make an expedited authorization decision and provide notice as expeditiously as the Member’s health condition requires and no later than seventy-two (72) hours after the receipt of the request for service.
BlueCare Tennessee may extend the seventy-two (72)-hour time period by up to fourteen (14) calendar days if the Member requests an extension, or if BlueCare Tennessee justifies (to the State agency upon request) a need for additional information and how the extension is in the Member’s interest.

### P. Utilization Management Resources

| Medical Necessity Decisions for all Service Types are made in accordance with the Medical Necessity Criteria published by the Division of TennCare. |

#### TennCare Rules

Published by the Division of TennCare, these rules can be found on the state’s website at [http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm](http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm).

#### BlueCross BlueShield of Tennessee Medical Policy Manual

The BlueCross BlueShield of Tennessee Medical Policy Manual contains general policies and medical policies approved by BlueCross/BlueCare Tennessee. **General policies** are broad categories referring to disease states. **Medical policies** address specific technologies that relate to various disease states.

Medical policies are based upon evidence-based research that seeks to determine the scientific merit of a particular medical technology or technologies. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association Technology Evaluation Center. The criteria are as follows:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is Medically Necessary, not Medically Necessary, Investigational, or Cosmetic. Many policies also contain a section on Medical Appropriateness. This is for use in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual). Providers may view the BCBST Medical Policy Manual in its entirety on the company website at [https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm](https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm).

#### MCG Guidelines

MCG

8910 University Center Lane, Suite 425
San Diego, California 92122-1085

- Primary & Pharmaceutical Guidelines
- Continuum of Care Guidelines
- Inpatient and Surgical Guidelines
- Home Health Guidelines (Case Management: Home Care)
- Recovery Facility Care Guidelines (Case Management: Recovery Facility Care)
- Rehabilitative Guidelines (BlueCare Tennessee adopted UM Criteria)
  - Inpatient Rehabilitation Admissions
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy
MCG has developed a series of Best Practices Guidelines regarding common Member care practices. These guidelines are reviewed and approved by a panel of BlueCare, TennCare Select, CHOICES, or ECF CHOICES practicing network Physicians in addition to the national panels used by MCG. There are times when BlueCare Tennessee must modify or redefine certain MCG criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be defined, or the decision criteria needs to be modified.) Modified Utilization Management Guidelines are published on the company website, www.bcbst.com, allowing Providers the opportunity to review and/or be aware of any changes or variances made to MCG guidelines by BlueCare Tennessee. Providers are notified thirty (30) days in advance of subsequent changes to these guidelines. When the nurse reviewer cannot approve a request, it is referred to a Physician for review.

If the BlueCare, TennCare Select, CHOICES, or ECF CHOICES Physician reviewer feels the request for authorization cannot be approved, the requesting Provider may appeal the decision (see Section XII. Highlights of Provider Agreement in this Manual for the appeal process). Please remember that the insurance benefit available for the Member is the focus of the discussion.

Upon request, a copy of the MCG guidelines (up to three (3) guidelines) may be sent to a Physician or Provider when a review resulted in non-authorization. Copies of any of the other guidelines mentioned above are also available upon request.

Effective April 1, 2012, BlueCare, TennCare Select, CHOICES, or ECF CHOICES will use the discharge criteria in the Centers for Medicare & Medicaid Services’ General Therapy Guidelines to aid authorization decision-making regarding adult outpatient physical therapy discharge criteria. CMS lists local coverage determination for outpatient physical therapy which indicates Medical Necessity guidelines. This will serve as an adjunct to MCG guidelines and the BCBST Medical Policy Manual to better clarify discharge criteria.

Durable Medical Equipment (DME) and Orthotic and Prosthetic (O&P) Guidelines

BlueCare Tennessee Medical Management Program utilizes Durable Medical Equipment Medicare Administrative Contractor (DME MAC) as a resource for review and determinations. DME MAC is utilized by BlueCare Tennessee for determining appropriate codes and Medical Necessity for durable medical equipment based on using tools for determining coverage when criteria is not available through BlueCross Medical Policy, MCG guidelines, and BlueCare Tennessee Modified Utilization Management Guidelines. These guidelines can be viewed online at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

DME medical policies may be either national or local. National policies are established by the Centers for Medicare & Medicaid Services (CMS). Local policies are established by the DME MAC. Local policies are jointly developed by the medical directors of the DME MAC. The intent of the policy development process is to provide the opportunity for input from the supplier and medical community to assure that the final policy is consistent with sound medical practice.

Q. Utilization Management Provider Appeals Process

It is the policy of BlueCare Tennessee to make available to treating Practitioners a Physician-to-Physician review to discuss by telephone, determinations based on Medical Appropriateness. A Physician-to-Physician discussion can be arranged by calling Utilization Management at 1-888-423-0131 for BlueCare, 1-800-711-4104 for TennCare Select, or 1-888-747-8955 for CHOICES/ECF CHOICES, Monday through Friday, 8 a.m. to 6 p.m. (ET). Provider office staff should only initiate a Physician-to-Physician discussion with one of our Medical Directors when the attending or ordering Physician requests, and is aware of the discussion.

1. Reconsideration
   Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCare Tennessee. This information may be submitted to BlueCare Tennessee from the Provider or Provider representative. All reconsideration requests should be
submitted using the **Provider Reconsideration** request form along with required information. Forms are located on the BlueCare Tennessee website at [http://bluecare.bcbst.com/providers/forms.html](http://bluecare.bcbst.com/providers/forms.html).

2. **Expedited Appeal**

An expedited appeal can be requested when the Provider believes that the adverse determination might seriously jeopardize the life or health of a Member and the services are either imminent or ongoing.

If a service is completed, the appeal does not qualify for an expedited appeal. The request for an expedited appeal should be initiated by telephone and should include any pertinent clinical information not originally submitted. An expedited appeal may or may not require a peer-to-peer conversation. An expedited appeal may be requested when the Provider believes that the adverse determination:

- could seriously jeopardize the life or health of the Member and the ability of the Member to regain maximum function; and/or
- would subject the Member to severe pain that cannot be adequately managed without the care or treatment.

An expedited appeal will be completed and written notification issued to the Member and Provider within approximately one (1) week from receipt of the request, however, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling Utilization Management at 1-888-423-0131 for BlueCare, 1-800-711-4104 for TennCare Select, or 1-888-747-8955 for CHOICES/ECF CHOICES, Monday through Friday, 8 a.m. to 6 p.m. (ET).

3. **Non-Compliance Denial Appeal**

If a party is dissatisfied with a non-compliance denial, they may appeal the denial. Appeals of non-compliance denials must be submitted within sixty (60) days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the Practitioner indicating the reasons for the appeal and a copy of the denial letter. A determination will be sent to the Provider and/or Member within thirty (30) days of the receipt of the request for appeal. If the party is still dissatisfied with the decision, he/she may proceed to Arbitration pursuant to Section II C. of the Provider Dispute Resolution Procedure.

4. **Standard Appeal**

The Standard Appeal process can be used if Reconsideration or an Expedited Appeal resulted in an adverse determination. Requests for Standard Appeals for denied services must be received in writing by the Utilization Management Appeals Department within sixty (60) days of the date of the initial denial notification. The request should include a copy of any pertinent clinical information, a copy of the denial letter and a statement from the Provider indicating the reasons for the appeal. All appeal requests should be submitted using the **Provider Appeal** form along with required information. Forms are located on the BlueCare Tennessee website at [http://bluecare.bcbst.com/providers/forms.html](http://bluecare.bcbst.com/providers/forms.html). A determination will be sent to the Provider and Member within thirty (30) days of the receipt of the request for appeal. **Fax** Appeal requests to:

```
BlueCare Tennessee Appeals Department
Attention: (BlueCare/TennCare Select, CHOICES/ECF CHOICES) UM Appeals Department (specify)
FAX: (423) 535-1959
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**Note**: Use of dedicated fax number will help ensure all faxed standard appeals are imaged into our system in a timely manner and make available the most current information to Providers when checking the status of an appeal.
Mail Appeal (Non-Specialty Pharmacy) requests to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402-0039

To submit Specialty Pharmacy Appeals requests:

Mail to: Magellan Rx Management
   Attn: Appeals Department
   P.O. Box 1459
   Maryland Heights, MO 63043

Phone: 1-800-424-8240
Fax: 1-888-656-6805

If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. D. of the Provider Dispute Resolution Procedure. For more information on the Provider Dispute Procedure, see Section XII. Highlights of Provider Agreement in this Manual.

5. Appeal to TennCare

Members with denied services can appeal to the Division of TennCare within sixty (60) days of receipt of the denial notice. Providers can appeal on the behalf of the Member by obtaining written authorization from the Member. The written authorization and appeal request can be submitted to:

TennCare Solutions Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593
FAX (toll-free) 1-888-345-5575

R. Continuation of Benefits for Private Duty Nursing and Home Health Agency Services for Members Over 21 Years

When a Member over age 21 years files an Appeal and requests Continuation of Benefits, and it is determined the current services will continue, the appeal will be expedited and a decision made quickly. As an expedited Appeal, it is important for home health agencies to work with BlueCare Tennessee in obtaining a new Physician order that can be used in the event the Appeal is upheld.

Continuation of Benefits requests for Members over the age of 21 for Private Duty Nursing and/or Home Health Aide will be approved if:

1. The Member is dependent on an invasive ventilator for at least twelve (12) hours each day with no end of the circuit (i.e., tracheostomy cannula) or,
2. The Member is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least twelve (12) hours each day in order to avoid or delay tracheostomy (requires medical review); or
3. The Member has a functioning tracheotomy and all the following elements are met:
   a. requiring suctioning
   b. oxygen supplementation
   c. receiving nebulizer treatments or requiring the use of cough assist/inexsufflator devices for persons with a functioning tracheotomy, at least one from each of the following medication and nutrition items must be met:
4. Medication (1) receiving medication via a gastrostomy tube (G-tube), or (2) receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and

5. Nutrition (1) receiving bolus or continuous feeds via a permanent access such as a G-tube, Mickey Button or Gastrojejunostomy tube (G-J tube), or (2) receiving total parenteral nutrition.

When a Member files an appeal and requests Continuation of Benefits for any services pending resolution of the appeal, Continuation of Benefits will be provided when all of the following criteria are met:

1. The Member files an appeal and requests Continuation of Benefits within ten (10) calendar days from notice of action by BlueCare Tennessee.
2. The service at issue is a covered benefit under the TennCare Program for the eligibility category in which the Member is enrolled.
3. The Member has not exceeded applicable benefit limits for the service being requested.
4. The appeal is a service (not a billing or reimbursement) appeal.
5. The appeal is for a type and amount of care the Member is currently receiving from TennCare (or was receiving at the time of notice of adverse action from BlueCare Tennessee). Note: If the care is being paid by third party insurance and TennCare is subject to financial responsibility for the care, Continuation of Benefits is applicable even if TennCare is not reimbursing any part of the care.
6. Except for certain exceptions as defined in TennCare Rules, there is a current Physician order for the service being requested.

Note: Continuation of benefits can also be requested for Members under age 21 years.

S. Services Subject to Retrospective Claims Review and Focused Review

The method by which a Member’s health care service claim is reviewed after service has been rendered and claim has been received, but before reimbursement is made. Abortion, Sterilization and Hysterectomy (ASH) claims and other claims not meeting specific parameters are subject to Retrospective Claims Review. Additionally, the following services are subject to Retrospective Claims Review:

- Potentially non-Covered Services including, but not limited to:
  - Investigational
  - Cosmetic
  - Infertility
  - Outpatient Weight Reduction Programs
  - Convenience Items

Note: Select procedures are subject to focused retrospective review utilizing chart review and standardized criteria on cases identified by recently developed, highly sensitive predictive modeling software.

Focused Retrospective Quality Review

Focused retrospective reviews are in-depth quality reviews of Provider and/or Practitioner medical record documentation identified by cost and utilization data to determine whether proper guidelines and standards of care were effectively utilized. The medical records of selected claims are reviewed for clinical documentation supporting the Medical Necessity of service for the claims as billed. The focused review will be conducted by BlueCare Tennessee’s Clinical Quality Improvement Department or Utilization Management Department and Medical Directors utilizing clinical review judgment found in medical policy, nationally recognized criteria, contracts, and processes.
Abortion, Sterilization and Hysterectomy (ASH)

Abortions, sterilizations and hysterectomies are reviewed to comply with federal regulations. The requirements for performing these procedures are explained in Section XIII. Abortion, Sterilization, Hysterectomy in this Manual. There may be specific consent and documentation requirements for payment. ASH requests are reviewed retrospectively. When a claim is submitted, it is reviewed for appropriateness and to determine if appropriate required documentation is complete. If forms are not completed correctly complying with federal guidelines, the claim will not be paid. Refer to Section XIII. Abortion, Sterilization, Hysterectomy in this Manual for Instructions in completing the form appropriately.

The Acknowledgement of Hysterectomy Information form (Medicaid Form TDHE-605), Sterilization Consent form, Certification of Medical Necessity for Abortion form and Hysterectomy Acknowledgement form are available in both English and Spanish and assistance will be provided in an alternative form of communication when necessary, in accordance with federal requirements. These forms may be accessed and printed online at https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html. If a Spanish translator is needed when completing the form, please call the Family Assistance Service Center at 1-866-311-4287.

Bariatric Surgery


Non-Covered Procedure

- Implantable sleeve (e.g., the Endo Bypass System) for the treatment of morbid obesity is not covered and is considered Investigational.
- Any device utilized for this procedure must have FDA approval specific to the indication, otherwise it will be considered Investigational.
- Laparoscopic greater curve placation (LGCP) (i.e., total vertical gastric placation, gastric imbrications, gastric pleat) for the treatment of morbid obesity is considered Investigational.

Covered Procedure (as Medically Necessary and in accordance with clinical guidelines established by BCBST Medical Policy)

- Bariatric surgery, using a laparoscopic or open procedure, for the treatment of morbid obesity is considered Medically Necessary if the Medical Appropriateness criteria are met.

Incontinence Supplies

The July 1, 2014, Budget Reduction Act requires that greater than 200 incontinence supplies per Member per month must be Medically Necessary. BlueCare Tennessee will perform a retrospective review on claims that exceed the allowable monthly supply. The review will require the Practitioner’s order and clinical records supporting the incontinent supply request.

T. Referrals

Completion of the referral form for BlueCare, TennCareSelect, CHOICES, or ECF CHOICES Members has been eliminated for Primary Care Providers (PCPs) referring to a participating specialist or to any emergency room. According to Contract, BlueCare Tennessee shall:

- allow a Member at least one (1) annual preventive care visit to a network obstetrician/gynecologist without obtaining a referral from a case manager or PCP;
- provide all PCPs and case managers with a current listing of referral Providers; and
- provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the Member to obtain one outside the network, at no cost to the Member.

Providers can access the BlueCare Tennessee Referral Directory on the company website, http://bluecare.bcbst.com/ or a paper copy is available only to BlueCare, TennCareSelect, CHOICES, or ECF CHOICES PCPs and OB/GYNs by calling the BlueCare Provider Service line, 1-800-468-9736. Note: Keep in mind, the paper copy is only current at the time of printing.
The information listed in this online directory is updated daily. As is the case with any directory, the listed Providers’ participation in the network is verifiable only up to the date the directory was updated. Providers join, as well as, leave the networks. It is very important to verify health care professionals’ and facilities’ continued participation in a network before referring a patient.

Although it is the Provider’s obligation to notify his/her BlueCare Tennessee patients of any intent to terminate participation in a network, we will also display termination dates beside the Provider’s name once notice is received. It is our intent to publish termination dates thirty (30) days prior to the actual termination effective date.

PCPs are still expected to direct Members care to emergency rooms and make appropriate appointments to participating specialists. **Note**: The current paper referral process is still required when referring a Member to an out-of-network Provider.

### U. Other Services

**Vision Services**  
For vision-specific benefits, see Section V. Billing and Reimbursement in this Manual.

**Dental Services**  
Dental services are provided through DentaQuest. Preventive, diagnostic and treatment services are covered for BlueCare, TennCare Select, or ECF CHOICES Members under age 21 years and do not require prior authorization. Dental services for Members age 21 years and older are not covered unless the Member is enrolled in ECF CHOICES and elects to utilize those services. If you have any questions or need additional information, please call DentaQuest Customer Service at 1-855-418-1623.

### V. Department of Children’s Services (DCS) and Safety Admissions

TennCareSelect is responsible for the medical care for children with Medicaid in State Custody. These children are managed by a Department of Children Services (DCS) worker. Even though initially a child may not be a TennCareSelect Member, when DCS places a child in state custody, the child becomes a TennCareSelect Member. TennCareSelect provides not only basic health care services, but also care coordination of all the health care services of children in custody. When a child with significant healthcare needs is placed into DCS custody, DCS works to find an appropriate placement where the child’s medical or behavioral needs can be addressed. Ideally, the DCS worker will find a foster home with appropriately trained foster parents. The child may also be placed in a Behavioral Health (BH) facility.

Infrequently, after hours or on the weekends, DCS is notified of a child with significant medical or behavioral needs that need to be taken into state custody on an immediate and urgent basis. Usually the child is in the ER and there is no place for the child to be placed due to the medical condition and needs of the child. When this happens, DCS will work to locate an appropriate home, but placement may not be possible for a few days. Due to the medical/BH needs, a foster family needs to be located and will need training on caring for the child. Since there is no safe discharge for the child who with physical or BH needs that require professional support, TennCareSelect will pay for the child to be admitted to the hospital until a safe residence is available for the child.

### W. Air Ambulance Transport Services

BlueCare Tennessee may cover Medically Necessary air ambulance transportation that is rendered by a professional ambulance service when the Member’s medical condition is such that the time needed to transport him/her by land, or the instability of transportation by land, poses a threat to his/her survival or seriously endangers the Member’s health.
Documentation must clearly support the Medical Necessity for air transport. Medical Necessity requiring air ambulance must be presented with the Member’s condition. If Medical Necessity is not shown, a more cost-effective alternative may be determined. Note: Air ambulance transportation requests are referred to and reviewed by the Transportation Coordination Unit.

Transportation of a Member from a capable facility to another facility solely to avail the Member of the services of a specific Practitioner is not covered by BlueCare Tennessee.

X. Emergency Services

BlueCare Tennessee communicates to its Members to go to the nearest emergency room if they are suffering from an emergency condition that does not allow time to contact their PCP.

Emergency services are covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition.

Emergency medical condition means a physical or behavioral condition manifesting as acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

When it is determined that an emergency medical condition does not exist, BlueCare Tennessee pays a screening fee only for the examination. When it is determined that an emergency medical condition does exist, BlueCare Tennessee pays for the Covered Services that are Medically Necessary, which includes payment of the screening fee. A $10.00 - $50.00 copay is charged to uninsured and uninsurable BlueCare or TennCareSelect Members presenting to the emergency room. This Copay amount is waived if the Member is admitted.

Behavioral Health Crisis Services

Behavioral health crisis services are provided for all TennCare Members. To arrange emergency crisis services, Providers should call:

**Adults (18 years and older)** 1-855-274-7471

**Children & Youth (under 18 years of age):**

<table>
<thead>
<tr>
<th>Region</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Memphis Region</td>
<td>1-866-791-9226</td>
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<tr>
<td>Rural West TN</td>
<td>1-866-791-9227</td>
</tr>
<tr>
<td>South Middle</td>
<td>1-866-791-9222</td>
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<tr>
<td>North Middle TN</td>
<td>1-866-791-9221</td>
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<tr>
<td>Mental Health Co-Op</td>
<td>1-865-726-0125</td>
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<tr>
<td>(Davidson)</td>
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<tr>
<td>Southeast TN</td>
<td>1-866-791-9225</td>
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<tr>
<td>East Region</td>
<td>1-866-791-9224</td>
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<tr>
<td>Frontier Health (NE TN)</td>
<td>1-877-928-9062</td>
</tr>
<tr>
<td>Helen Ross McNabb</td>
<td>1-865-539-2409</td>
</tr>
<tr>
<td>(Monroe, Blount, Sevier,Loudon, Knox)</td>
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</tbody>
</table>

**Crisis Response Team/Mobile Crisis Team**

The Crisis Response Team/Mobile Crisis Team (CRT/MCT) provides onsite, mobile assessment to BlueCare Tennessee Members in an active state of crisis 24-hours-a-day, 7-days-a-week. The purpose of the CRT/MCT is to rapidly respond, effectively screen, and provide early intervention to help those individuals who are in crisis, and insure their entry into the continuum of care at the appropriate level.

**Crisis Respite and Crisis Stabilization Services**

Behavioral health crisis respite services provide immediate shelter to Members with emotional/behavioral problems that are in need of emergency respite. BlueCare Tennessee will ensure that behavioral health crisis respite services are provided in a BlueCare Tennessee approved community location. BlueCare
Tennessee will ensure behavioral health crisis stabilization services are rendered at sites licensed by the State. These services are more intensive than regular behavioral health crisis services in that they require more secure environments, highly trained staff, and typically have longer stays.

BlueCare Tennessee utilizes guidelines to respond and address the urgent/emergent safety issues of its BlueCare and TennCare Select members. The medical management supervisor is notified immediately for urgent action, if any information is received by telephone of suicide attempt, assault, abuse or a safety threat.

Y. Investigational Services

Investigational Services are considered by BlueCare Tennessee to be not Medically Necessary. New and established technologies are researched and evaluated by BCBST Medical Policy Research and Development Department and are assessed using sources that rely upon evidence based studies. Input is also sought from our network Providers.

Investigational Services are defined as a drug, treatment, therapy, procedure, or other services or supply that does not meet the definition of Medical Necessity:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of its use or proposed use;
2. is the subject of a current Investigational new drug or new device application on file with the FDA;
3. is being provided according to the Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for determination of Medical Necessity);
4. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with convention alternatives;
5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS);
6. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings;
7. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives; or
8. the service or supply is required to treat a complication of an Investigational service.

The Medical Director shall have discretionary authority to make a determination concerning whether a service or supply is an Investigational service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any and all of the following, at his or her discretion:

1. the Member’s medical records;
2. the protocol(s) under which proposed service or supply is to be delivered;
3. any consent document that the Member has executed or will be asked to execute, in order to receive the proposed service or supply;
4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by the Member;
5. regulations or other official publications issued by the FDA and HHS;
6. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational services; or
7. the findings of the BlueCross BlueShield Association Technology Evaluation Center or similar qualified evaluation entities.

These criteria are used in making such determinations as to whether or not a service is considered to be Investigational or Medically Necessary. Providers have access to these policies via the BCBST Medical Policy Manual on the Provider page of the company website, www.bcbst.com and are also informed of determinations via our monthly BlueAlert Newsletter.
Z. Health Department Services

BlueCare Tennessee will reimburse health departments $10.00 for the administration of immunizations provided to the Health Department at no cost; health departments should bill BlueCare Tennessee with zero (0) charges for the drug. All Managed Care Organizations are required to track immunization services provided to Members. Please refer to Section XIV. Preventive Care of this Manual for immunization program guidelines.
IX. OB Services

The OB Practitioner or the Primary Care Provider (PCP), if the PCP is providing the prenatal care, should submit the Maternity Care Management Notification form within 30 days of the Member’s first appointment to help ensure our pregnant Members receive the appropriate maternity services. The completed Maternity Care Management Notification form can be faxed to 423-854-6033. The Maternity Care Management Notification form is found on the BlueCare Tennessee website at http://bluecare.bcbst.com/providers/forms.html. The Maternity Care Management Notification form can also be submitted 24-hours-a-day, 7-days-a-week via Availity, BlueCare Tennessee’s secure area on its website, http://bluecare.bcbst.com.

Network facilities are not required to notify BlueCare or TennCare Select of maternity delivery admissions. These services are not subject to prior authorization/notification requirements, but may be subject to retrospective review based on Medical Policy. However, all services provided by out-of-network Providers require prior authorization and all NICU admissions require authorization regardless of network status.

Note: If sterilization services are requested, the treating OB is required to follow the state sterilization consent process.

A. Prenatal Standards/Quality Improvement Studies

Contracted BlueCare and TennCare Select Practitioners must participate in any BlueCare Tennessee ongoing monitoring activity or focus study involving OB services to BlueCare and TennCare Select Members, in accordance with the Contractor Risk Agreement.

Prenatal care must be delivered in accordance with current American Congress of Obstetrics and Gynecologist (ACOG) guidelines for perinatal care. These guidelines are available for purchase online at, http://sales.acog.org/Guidelines-for-Perinatal-Care-Seventh-Edition-P262C54.aspx.

B. High-Risk Pregnancies Referral Guidelines

Special attention should be given to BlueCare and TennCare Select Members who are considered to have a high-risk pregnancy. PCPs should follow the American College of Obstetrics and Gynecologist (ACOG) criteria in referring high-risk pregnancies to either an OB/GYN or perinatologist.

BlueCare Tennessee Population Health Management Specialists (registered nurses with obstetric experience) outreach to prenatal Members through the CaringStart Maternity Program. This program is designed to reinforce the importance of prenatal care and self-care management through education and intervention in order to increase the number of healthy births and improve pregnancy outcomes.

BlueCare Tennessee encourages Practitioners to enroll Members in CaringStart Maternity Program as soon as pregnancy is diagnosed. Practitioners can enroll a Member in the program by submitting a completed Maternity Care Management Notification form by calling 1-888-416-3025, or via eHealth Services Web submission through Availity, the secure area on our company website, http://bluecare.bcbst.com available 24-hours-a-day, 7-days-a-week. Practitioners can call 1-800-468-9736 to verify BlueCare eligibility, or 1-800-276-1978 to verify TennCare Select eligibility.

Members are automatically enrolled in the CaringStart Maternity Program when their pregnancy has been identified through the Maternity Care Management Notification form and/or through various other referral sources. Once enrolled, a comprehensive health assessment may be conducted to further identify risk factors that will guide prenatal education.

Members can receive an electric breast pump with a Physician order and by completing the information at http://breastpumpsmedline.com or at http://www.breastpumps.aeroflowinc.com/qualify-through-insurance/.

The program supports the Practitioner/patient relationship and plan of care; emphasizes prevention of
further complications throughout pregnancy by utilizing evidence-based clinical practice guidelines and patient empowerment strategies. It also links mothers-to-be with important pregnancy-related healthcare information needed to make healthy choices during pregnancy. Members enrolled in the program can call CaringStart obstetric nurses at 1-888-416-3025 with questions they may have throughout their pregnancy.

The following criteria may be used to identify Members with a high-risk pregnancy. This list is intended only as a guideline, is not all-inclusive, and does not necessarily determine eligibility for this program. BlueCare and TennCareSelect Members are eligible for CaringStart upon diagnosis of pregnancy.

- **Member's obstetric history**
  * Spontaneous abortion, any trimester;
  * Previous C-Section;
  * Elective abortion, any trimester;
  * Still birth or infant death;
  * Pre-term deliveries at less than 37 weeks;
  * Pre-term labor;
  * Hx of cervical dilation or effacement at less than 36 weeks;
  * Hx of abruption placenta;
  * Low-birth-weight infant; and
  * Baby with neuralgic deficit, birth injury, or malformation

- **Member's medical history**
  * Heart disease (organic);
  * Pulmonary HTN, OPD, Cystic Fibrosis, or Asthma with frequent medications;
  * Diabetes: GDM or IDDM;
  * Chronic or Pregnancy Induced HTN;
  * Poly/Oligohydramnios;
  * HIV, Rubella, Parvovirus, Varicella, Herpes (primary), or Toxoplasmosis;
  * Systemic Lupus Erythematosus;
  * Chronic UTI;
  * Sickle Cell Anemia, DIC, ITP or other Hemoglobinopathies;
  * Hyperemesis Gravidarum with metabolic changes;
  * Incompetent cervix or Cerclage;
  * HELLP syndrome;
  * Cone biopsy/LEEP;
  * Renal Insufficiency or Liver Disease;
  * Thrombophlebitis or Pulmonary Embolism;
  * Seizure disorder, Myasthenia Gravis, or Multiple Sclerosis; or
  * Addison's Thyroid, or Parathyroid Disease.

- **Member's Social/Demographic Status**
  * Under age 16/over age 35, Nullipara;
  * Over age 40,Multipara;
  * Less than one year since last birth;
  * Multifetal;
  * Significantly ambivalent or negative feelings toward pregnancy under 20 weeks;
  * Inadequate support system (nuclear or extended family);
  * Current or historically significant psychiatric problems;
  * Tobacco use;
  * Chronic alcohol or prescription medication use; substance use disorder; or
  * Eating disorders.

To have a BlueCare or TennCareSelect Member evaluated for the program, call 1-888-416-3025 and ask for the CaringStart® Program.
C. Women, Infants and Children (WIC) Program

The Women, Infants and Children Program (WIC) provides financial support for the nutritional needs of pregnant women and of infants and children five (5) years of age and younger with certain nutritional needs.

WIC is part of a network of integrated health services available through the Department of Health and various health and social service agencies. To qualify BlueCare or TennCareSelect Members for WIC, Practitioners must examine their Members and certify them to be at nutritional risk. Once the Member is certified, the Practitioner should refer the Member to the Tennessee Department of Health for enrollment into the WIC program.

Authorization consists of recording certain measures as required by the WIC program and may be obtained from any procedure conducted as part of a child health or prenatal care exam. The following measures must be recorded on the Practitioner’s letterhead stationery or prescription pad and given to the Member for referral to the WIC program:

- Height
- Weight
- Hematocrit or hemoglobin

Practitioners must record the date referral was made to the WIC program in the Member’s medical record.

More information about the WIC program can be found by contacting the county health department where the Member resides or contact Tennessee WIC Program at 1-800-342-5942.

D. Presumptive Eligibility

To encourage early entry into prenatal care, federal law allows states to give temporary Medicaid coverage, or Presumptive Eligibility, to income-eligible pregnant women. Tennessee presumptive eligibility grants pregnant women TennCare benefits while allowing time to complete formal TennCare application. Practitioners should direct their Tennessee patients who are pregnant and without health insurance to the local health department to apply for presumptive eligibility. A pregnant woman may present in person at any county health department in the state of Tennessee to file an application for presumptive eligibility. A list of county health departments is available at https://www.tn.gov/health/health-program-areas/localdepartments.html.

Presumptive Eligibility - An established period of time during which certain pregnant women are eligible for TennCare Medicaid. During this period of time the presumptively eligible Enrollee must complete a full application for Medicaid in order to stay in the program. Eligibility extends from the presumptive eligibility effective date through the end of the following month unless a full Medicaid application is completed. When a full Medicaid application is completed, presumptive eligibility is provided until an eligibility determination is made on the full Medicaid application. In order to continue TennCare coverage after the initial 45-day period, the woman must apply through https://www.healthcare.gov/ or call the Health Insurance Marketplace at 1-800-318-2596 and be approved for enrollment in the TennCare program.

Women who are presumptive eligible are entitled to all TennCare benefits including all rights, privileges and responsibilities. Benefits are not limited to prenatal care; presumptive eligible women are entitled to all covered preventive care, medical services, pharmacy benefits, inpatient admissions and any other Medically Necessary care offered by TennCare.

TennCare requires that women who are past their first trimester of pregnancy receive an initial prenatal appointment within fifteen (15) days. Women who are still in their first trimester are subject to the usual access standard of three (3) weeks for the initial appointment.

Note: If application and approval are not completed within the 45-day time frame or TennCare eligibility is denied, BlueCare Tennessee will only provide coverage for the services rendered during the presumptive eligibility period. The woman will be responsible for the cost of any care received after the 45-day presumptive period.
The following guidelines apply for BlueCare or TennCareSelect Presumptive Eligible Enrollees:

1. Only Tennessee Health Departments are authorized to grant presumptive eligibility to pregnant women residing in the State of Tennessee. The health department requires a valid pregnancy test as proof of pregnancy and some preliminary income information for enrollment consideration.

2. Pregnant women meeting the above criteria are enrolled with a presumptive eligible status. The health department completes the Tennessee Medicaid Presumptive Eligibility form, PH 3097, which, also acts as the Enrollee’s temporary TennCare identification. Upon TennCare approval, the Member will receive a BlueCare or TennCareSelect ID card in approximately two (2) weeks. The Member should present her carbon copy of the presumptive eligibility form during the 45-day period or her ID card each time she seeks care.

3. The health department or Member makes the first prenatal appointment with a BlueCare/TennCareSelect participating Practitioner according to the schedule outlined below:

   - First Trimester: First prenatal appointment within 3 weeks
   - Second Trimester or Third Trimester: First prenatal appointment within 15 days

4. Enrollee presents her carbon copy of the Presumptive Eligibility form or Member ID card as evidence of enrollment. The Practitioner should verify that the form indicates BlueCare/TennCareSelect (MCO # 00-02 or 00-19) is the Enrollee’s designated MCO. (Note: New Members are automatically assigned a Primary Care Provider (PCP). The PCP’s name is listed on the Member’s ID card.

5. Practitioners should verify eligibility by calling their Provider Services line (see Section I. for appropriate numbers) during the presumptive eligibility period. If BlueCare Tennessee does not show eligibility information in its system on a Member who presents a presumptive eligibility form to a Practitioner, BlueCare Tennessee will contact the issuing health department to resubmit eligibility information. A BlueCare Tennessee customer service associate will forward eligibility results via telephone to the Practitioner’s office.

BlueCare Tennessee is required by the Division of TennCare to inform Practitioners that any unreasonable delay by the Practitioner in providing care to a pregnant woman seeking prenatal care is considered by BlueCare Tennessee as a material breach of contract.
X. Population Health Management Program

BlueCare Tennessee is committed to promoting a healthy lifestyle, reducing the impact of chronic disease, improving the number of healthy births, and improving pregnancy outcomes. We evaluate the entire enrollee population and identify enrollees for specific programs according to risk rather than disease-specific categories.

These services are provided to BlueCare, TennCareSelect, CoverKids\(^1\) and SelectCommunity\(^2\) Members at no extra cost. Additionally, all care coordination services are provided for CHOICES\(^3\)/ECF CHOICES\(^4\) Members at no extra cost. All BlueCare, TennCareSelect, CoverKids, SelectCommunity and CHOICES/ECF CHOICES Members are eligible for these programs regardless of primary or secondary coverage.

\(^1\)The CoverKids plan provides comprehensive health coverage for qualifying children under age 19 years and pregnant women. The coverage includes an emphasis on preventive health services and coverage for Physician services, hospital visits, vaccinations, well-child visits, developmental screenings, behavioral health care services, pharmacy, prenatal and postpartum care, and vision and dental care. (For specifics, see Section XVIII. CoverKids, in this Manual).

\(^2\)SelectCommunity is an integrated Care Management Program created within TennCareSelect for certain persons with Intellectual Disabilities. Eligibility for this program is determined by the Division of TennCare and is open to persons enrolled in one of the State’s three (3) Section 1915(c) Home and Community-Based Services Waiver programs for persons with intellectual disabilities as well as Members of the former Arlington Class residing in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). (For specifics, see Section XXIII. SelectCommunity, in this Manual).

\(^3\)The CHOICES Long-Term Services & Supports (LTSS) program promotes quality and cost-effective coordination of care for CHOICES Members having chronic, complex, and complicated health care, social service and custodial needs. LTSS includes care in a nursing facility, as well as care at home or in the community, known as Home and Community-Based Services (HCBS). All CHOICES Members are stratified into risk categories to ensure the health care provided to them is the most appropriate Population Health Levels. All Members receive Level 2 Chronic Care Management interventions due to their comorbidities. CHOICES Care Coordinators have primary responsibility for each CHOICES Member’s Population Health Intervention. The CHOICES Care Coordinator provides disease process education materials to Members. The Care Coordinator also addresses Member’s condition-related lifestyle issues, adherence to meeting plan goals and self-awareness of co-morbid states. CHOICES Care Coordinators lead coordination as needed with the Member’s Providers for development and implementation of an individualized treatment plan that is integrated into the Member’s Person Centered Support Plan (PCSP). CHOICES Care Coordinators may reach out to a Population Health Case Manager if additional assistance is needed. (For specifics, see Section XXII. CHOICES, in this Manual).

\(^4\) The TennCare Employment and Community First (ECF) CHOICES program is a managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program. ECF CHOICES assists individuals with disabilities in leading the life they want to live by providing supports in a person’s home or in the community. Supports that are individualized help Members obtain and maintain a job, be actively engaged in their community and live as independently as possible.

ECF CHOICES is designed for people with intellectual and other developmental disabilities who are not currently receiving services. ECF CHOICES offers:

There are three benefit groups in the ECF CHOICES Program:

- **Group 4: Essential Family Supports** or “Family Support services” are for people who live at home with their family. Members in this group may be nursing home level or care be at risk of needing nursing home level of care. The services in this group provide supports to the Member and help the family continue to provide supports to the Member as well.
Group 5: Essential Supports for Employment and Independent Living or “Essential Support services” are for adults age 21 and older, but are available for 18-20 year olds if they need the Community Living Support benefit. People in this group would be at risk of needing nursing home level of care if some services were not in place to support them.

Group 6: Comprehensive Supports for Employment and Community Living "Comprehensive Support services" are only for adults age 21 and older and are available for 18-20 year olds if they utilize the Community Living Support benefit. Members in this group would qualify to get care in a nursing home.

Note: Members enrolled in ECF CHOICES are not eligible to be enrolled in the SelectCommunity program at the same time. (For specifics, see Section XXIII. ECF CHOICES, in this Manual).

A. Components

Care Management staff connect Members to services that may be outside of the benefit that assists Members in coping with their illness and helping them maintain their functioning in the community. This approach shall include the following risk levels and Programs:

1. Helping healthy individuals stay healthy

   Wellness, Prevention, and Health Promotion
   Wellness, Prevention, and Health Promotion is a self-directed program with a goal of helping healthy Members stay healthy – emphasizing primary and secondary prevention. The program provides general health information quarterly that includes:

   - How to be proactive in their health;
   - How to access a primary care provider;
   - Preconception and interconception health, to include dangers of becoming pregnant while using narcotics;
   - Age and/or gender appropriate wellness preventive health services (e.g., “knowing your numbers”);
   - Assessment of special population needs for gaps in care (e.g., recommended immunizations for children and adolescents);
   - Health promotion strategies (e.g., discouraging tobacco use and/or exposure, weight management, stress management, physical activity, substance abuse prevention);
   - Healthy nutrition;
   - Other healthy and safe life styles;
   - Information on after hours assistance with urgent or emergent member needs; and
   - Clinical reminders around HEDIS/gaps in care.

2. Helping Members manage their own health risk

   Health Risk Management
   Health Risk Management is a self-directed program identifying Members with low acuity chronic conditions and potential health risks and then empowering them with the tools and educational materials necessary to make the most informed decisions regarding their health.

   The focus of Health Risk Management is behavior change through education using evidence-based guidelines. Our goal is to empower Members to become more effective at self-management of their condition. The Program focuses on specific interventions depending on the Member’s risk. This is available to BlueCare, TennCareSelect, CoverKids and CHOICES Members having chronic diseases that are prevalent in a significant number of Members or for Members with other chronic diseases utilizing resources in their regional population.
Communications include self-management education emphasizing:

- Knowledge of the chronic condition;
- Importance of medication adherence;
- Appropriate lifestyle/behavioral changes;
- Management of the emotional aspect of their condition; and
- Self efficacy and support

Members are also advised we provide:

- Individualized support for self management if member desires to become engaged;
- 24/7 Nurse advice line;
- Health coaching;
- Weight management; and
- Tobacco cessation support.

**Pregnancy**

All Members identified as being pregnant receive an outreach call to perform a Pregnancy Health Risk Assessment (HRA). Members are screened to identify any high-risk problems in the pregnancy to include tobacco use, mental illness, and substance use disorder.

Should maternal and fetal health problems arise because of the pregnancy or the Member is referred by an OB/GYN Provider as high risk, the Member is referred to a maternal-fetal medicine specialist and is enrolled in our High Risk Maternity Program. This can occur anytime maternal and fetal health problems arise because of the pregnancy.

Pregnant Members who have not been identified as high risk are enrolled in our CaringStart® Maternity Management Program. These Members are monitored throughout the pregnancy. The CaringStart® Maternity Management Program includes:

- Screening women for development of high-risk problems in pregnancy; and
- Referring women to maternal-fetal medicine specialists during pregnancy or when maternal and fetal health problems arise because of pregnancy.

The Maternity Care Management Notification form can be found on the company website at https://bluecare.bcbst.com/providers/forms.html.

Upon identification of pregnancy, all Members receive a prenatal packet containing information on the following:

- Encouragement to access Text4Baby;
- Access number to maternity nurse/social worker if Member wishes to engage in monthly maternity management;
- Preterm labor education;
- Breast feeding;
- Information on obtaining breast pumps;
- Secondhand smoke;
- Safe sleep;
- Specific trimester health information;
- Importance of postpartum visit;
- Importance of screening for postpartum depression;
- HUGS/CHANT Tennessee Department of Health information;
- Inter-conception health to include dangers of becoming pregnant while using narcotics;
- Availability of tobacco cessation benefits, support and referrals to resources such as:
  - The Tennessee Tobacco Hotline
  - Healthy Pregnancy Education
  - Substance use during pregnancy
  - Baby & Me Tobacco Free
- Contact information and advisement to call back if questions arise or if assistance is needed with service coordination or other issues.
Care Coordination

Care Coordination is available for all Members needing assistance with navigating the health care process or transitioning from one health care setting to another. This includes:

- Members discharged from inpatient and residential mental health or substance use disorder programs. We help ensure Members have discharge appointments, keep appointments and are connected to the additional resources that are required for the Member to be safely maintained at home in the community. These services include but are not limited to: Housing, Social Services, Social Supports, and other Community Services.
- Members who have been identified as utilizing emergency department services and those with reported frequency of emergency department visits. We reach out to the Member to educate on appropriate use of emergency services, alternative health care settings and resources for non-emergent care, and establish Members with their PCP/Medical Home.
- Special needs children for those identified as participating in Individual Education Plans (IEP).
  - Special needs children are children who require aid for certain disabilities that may be behavioral, medical or psychological.
- Children identified as having elevated blood lead levels (EBLL).
- Members traveling greater than 90 miles for care. We work to locate Providers closer to the Member’s home, and assist with providing available community resources for transportation arrangements as appropriate. Note: Transportation is not a covered benefit for CoverKids.
- Members receiving hospice care.
- Coordination of benefits for Members receiving HCBS DIDD Waiver Services.
- Coordination of benefits for Members enrolled in a Medicare Dual Special Needs Plan.
- Coordination of benefits for Members transitioning to adult benefit limit for home health and/or private duty services.

3. Helping individuals with complex health problems better manage their condition

High Risk Management

The focus of High Risk Management is behavior change, education, evidence-based guidelines, compliance, self-management and Physician support for Members with chronic conditions. High Risk Management is designed to help maximize Member health status and improve health outcomes.

Utilizing state-of-the-art technology and risk stratification tools, we identify Members that have the highest acuity scores. We outreach to these Members to perform an assessment using evidence-based practice guidelines and a team of experienced health care professionals to provide an individualized approach to condition management. The High Risk Management supports the Practitioner/patient relationship and plan of care, and empowers participants to become more effective at self-management of their condition.

This approach shall include the following risk levels and programs:

a. Chronic Care Management

This program is an integrated clinical and behavioral chronic condition program. All Members are assessed for both physical health and behavioral health management services. Members with both physical and behavioral health case management needs will have a single case manager who will coordinate all the needs of that Member. Newborns with special needs (to include discharge planning) are managed in this program.

For CHOICES and ECF CHOICES Members, the CHOICES Care Coordinator or ECF CHOICES Support Coordinator maintains primary responsibility for coordination of all the Member’s physical health, behavioral health, and long-term care services. The Population Health staff serves as a resource/consultant in the identification, care plan development, and implementation of the Member’s Population Health plan/Population Health interventions but does not supplant the role and responsibilities of the Care and Support Coordinator.
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We use the Case Management Society of America (CMSA) Integrated Case Management (ICM) Model. Our clinical and behavioral staff is certified to perform the assessments in a manner designed to build rapport, improve engagement and identify Member needs in collaboration with the Member and the Member’s Providers.

For Members enrolled in the program, we provide a minimum of monthly interactions with the Member that includes activities, interventions, and educational materials to:

- Develop a supportive Member and health coach relationship;
- Provide disease specific management skills such as medication adherence and monitoring of the Member’s condition;
- Negotiate with Members for appropriate health and behavioral changes;
- Teach problem solving techniques;
- Evaluate and support the emotional impact of Member’s condition;
- Encourage Self efficacy;
- Provide referrals and linkages to link Members with medical, social, educational and/or other Providers or programs and services to address identified needs;
- Provide face-to-face visits/contact with the Member, as applicable;
- Conduct regular and sustained monitoring and follow-up;
- Assess the individual’s understanding and readiness to change;
- Provide the Member with information specific to the Member’s condition;
- Provide information about the Member’s condition to caregivers who have the Member’s consent;
- Address barriers to treatment including access, transportation, financial, cultural, religious, and ethnic beliefs;
- Encourage Members to be proactive in their care and to communicate with their Practitioners about their health conditions and treatment;
- Collaborate around goal setting and expected outcomes;
- Identify and resolve potential barriers to optimal self-management;
- Serve as liaison to coordinate other services including website tools and community resources;
- Participate in collaboration and communication with the Member’s medical home, the Behavioral Health Provider (with Member consent), and other Care Management Team members; and
- Prevent complications.

Members needing specific chronic condition management are enrolled in the appropriate CareSmart® and CaringStart® Programs available to BlueCare, TennCareSelect, or CoverKids Members with chronic diseases that are prevalent in a significant number of Members, or Members with other chronic diseases utilizing health resources in their regional population. This may include, but not limited to Members with one or more of the following conditions:

- Schizophrenia
- Diabetes
- Asthma
- Major Depression
- Coronary Artery Disease
- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Bipolar Disorder

b. High Risk Maternity
Pregnant Members identified as being high risk receive all of the pregnancy educational information in addition to monthly contact by a High Risk OB Case Manager that may include a face-to-face visit if needed.

The case manager works to support self management and performs follow up to ensure the Member is established with a high risk OB provider for the pre-natal and post partum care. The case manager also provides information on the availability of tobacco cessation benefits, support and referrals to cessation services including the TN Tobacco Quit Line and Baby & Me Tobacco Free. Should referrals to appropriate community–based resources be needed, the case manager performs follow-up for these referrals.

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The OB case manager also provides Members:

- Telephone contact number for after hours assistance with urgent or emergent needs; and
- Clinical reminders around HEDIS/gaps in care.

c. Complex Case Management

Complex Case Management is the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes. The goal is to facilitate the delivery of appropriate individual health care services across the continuum of care in various settings for Members with complex and catastrophic conditions. The Intensive Medical Case Management Program monitors compliance with the National Committee for Quality Assurance (NCQA) standards in order to maintain accreditation.

Members seeking or waiting for a transplant are also managed in Complex Case Management. The Transplant Case Manager’s focus is on the entire spectrum of transplant care. The care of the Member is managed from the time he/she is approved for transplantation services and continues through the post-procedure or longer if services are deemed transplant-related and continue to be necessary.

The Member receives monthly contact from the case manager and may receive a face-to-face visit by the case manager if needed. The goal of the program is to:

- Develop a supportive Member and health coach relationship;
- Provide disease specific management skills such as medication adherence and monitoring of Member’s condition;
- Negotiate with Members for appropriate health and behavioral changes;
- Teach problem solving techniques;
- Evaluate and support the emotional impact of Member’s condition;
- Encourage Self efficacy;
- Provide referrals and linkages to link Members with medical, social, educational and/or other Providers or programs and services to address identified needs;
- Conduct regular and sustained monitoring and follow-up;
- Assess the individual’s understanding and readiness to change;
- Provide the Member with information specific to the Member’s condition;
- Address barriers to treatment including access, transportation, financial, cultural, religious, and ethnic beliefs;
- Encourage Members to be proactive in their care;
- Collaborate around goal setting and expected outcomes;
- Identify and resolve potential barriers to optimal self-management;
- Serve as liaison to coordinate other services including website tools and community resources;
- Participate in collaboration and communication with the Member’s medical home, the Behavioral Health Provider (with Member consent), and other Care Management Team members;
- Prevent complications;
- Provide after hours assistance with urgent or emergent Member needs; and
- Provide clinical reminders around HEDIS/gaps in care.

With the Member’s permission, Providers can also access the Member’s record, serve as a resource, and enter information important to the Member’s care. CareAdvance manages individual health records for Members and allows Members and their Care Management Team to communicate in accordance with federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. Referral Criteria

The following grid provides contact telephone numbers and identifies conditions (not intended to be all-inclusive) for use in referring BlueCare, TennCareSelect, and CoverKids Members for care management:
## Care Management Program Referral Guidance

<table>
<thead>
<tr>
<th>Care Management Program</th>
<th>Referral Guidance</th>
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</thead>
<tbody>
<tr>
<td><strong>Health Risk Management and Care Coordination</strong></td>
<td>- Allergies&lt;br&gt;- Arthritis&lt;br&gt;- Asthma&lt;br&gt;- Bipolar Disorder&lt;br&gt;- CAD&lt;br&gt;- Cardiovascular Disease&lt;br&gt;- COPD&lt;br&gt;- Diabetes&lt;br&gt;- Gastrointestinal Disorder&lt;br&gt;- Heart Failure&lt;br&gt;- Kidney Disease&lt;br&gt;- Major Depression&lt;br&gt;- Migraines&lt;br&gt;- Obesity&lt;br&gt;- Pregnancy&lt;br&gt;- Respiratory disease&lt;br&gt;- Schizophrenia&lt;br&gt;- Other conditions that are prevalent in the regional population&lt;br&gt;- Members with above conditions that have screened positive for mental illness or substance use disorder. Members with behavioral health issues that have medical conditions that are not being appropriately addressed.</td>
</tr>
<tr>
<td><strong>Phone</strong> 1-888-416-3025 &lt;br&gt;<strong>Fax</strong> 1-800-421-2885</td>
<td><strong>Coordination of Benefits</strong>&lt;br&gt;- Members receiving HCBS DIDD Waiver Services&lt;br&gt;- Members enrolled in a Medicare Dual Special Needs Plan&lt;br&gt;- Members identified as having three (3) or more ER visits in a rolling three-month time frame&lt;br&gt;- Members identified through ER criteria as not requiring emergent care.</td>
</tr>
<tr>
<td><strong>Emergency Service Management</strong></td>
<td><strong>MH/SA Discharge Planning</strong>&lt;br&gt;- All Members discharged from inpatient and residential treatment programs.</td>
</tr>
<tr>
<td><strong>Emergency Department Redirection</strong></td>
<td><strong>Chronic Care Management and Complex Case Management</strong>&lt;br&gt;- Pediatric Members with special needs, including but not limited to blindness, deafness, IEP, IFSP, TEIS&lt;br&gt;- Children identified with EBLL greater than or equal to 5 mcg/dl&lt;br&gt;- Members needing assistance managing their illness&lt;br&gt;- Members with barriers to self-care&lt;br&gt;- Suspected child abuse&lt;br&gt;- Members needing assistance managing at home&lt;br&gt;- Members needing assistance accessing care&lt;br&gt;- Frequent inpatient admissions/emergency room utilization&lt;br&gt;- Newborns with special needs to include discharge planning&lt;br&gt;- Provider support with co-created care plans&lt;br&gt;- Tennessee residents admitted to out-of-state facility</td>
</tr>
</tbody>
</table>
C. Enrollment

To refer Members who would benefit from any of our programs, we encourage Practitioners to utilize the program referral form.

The CareSmart® Population Health Management fillable referral form can be found on BlueCare Tennessee website at https://bluecare.bcbst.com/forms/Provider%20Forms/CareSmart_Population_Health_Fax_Email_Form.pdf. Print completed form and fax to 1-800-421-2885 or e-mail to DMScreeners_GM2@bcbst.com.

Providers having questions or in need of more information about our CareSmart® and CaringStart® programs can call 1-888-416-3025.

**Note: Special information for our Medical Homes:**
When Members are enrolled and engaged in a program, the medical home is notified by telephone or in writing. While the Member is actively participating in the education program, he/she is assigned a Registered Nurse/Behavioral Health Clinician who will assess, identify and support the Member’s needs, and reinforce education. There is collaboration with the Member’s medical home and treating Providers to support the Care Plan on an ongoing basis. The medical home is notified of risks identified through the HRA and the Member’s ongoing participation in the program. We are also able to identify gaps in care as defined by HEDIS criteria. The medical home is informed telephonically about gaps in care for their individual patients who are participating in the program. The medical home is encouraged to discuss these gaps with the Member at their earliest opportunity. BlueCare Tennessee Care Management Team works with participating Members and their medical home to resolve these gaps.
D. Evaluation of Population Health Management Programs

The Population Health Management department monitors Member satisfaction, Care Plan adherence, Provider adherence to the guidelines, and operational details such as program enrollment, contact rate, and number of cases opened. The program is evaluated on an annual basis using performance measures that are compared to measurable benchmarks and goals including HEDIS. Key performance measures in the annual evaluation include the rate of emergency room utilization, hospitalizations, and Member satisfaction. Based on outcome measurements and Member satisfaction data, program activities are added or modified for continued quality improvement of effective and cost-efficient services.

E. Contact Us

If you have questions about the programs, or you would like a copy of the educational material, you may contact our Population Health Management department telephonically at:

Phone: 1-888-416-3025
Fax: 1-800-421-2885
XI. Quality Improvement Program

A. Introduction

BlueCare Tennessee is committed to improving the quality and safety of care and service to its Members. BlueCare Tennessee demonstrates this commitment through the implementation of a comprehensive Quality Improvement Program (QIP), which provides the structure that supports quality improvement activities.

The QIP directs the management, evaluation and improvement of quality, appropriateness and accessibility of health care services and promotes the integration of the physical health, behavioral health, and long-term services to our Members, while achieving Member and Provider satisfaction.

The QIP provides leadership for implementation of comprehensive quality improvement initiatives for BlueCare Tennessee to meet the demographic and epidemiological needs of the population served. Through various initiatives such as outreach events and focus group activities in communities identified with needs, BlueCare Tennessee is able to provide local solutions with meaningful results.

Purpose

The purpose of the QIP is to design, implement, evaluate, and document initiatives for improvement in clinical and process performance in a systematic, coordinated and continuous manner. This is accomplished through research and implementation of best practices and/or evidence-based practice established through studies and peer review publications demonstrating comparative effectiveness outcomes. BlueCare Tennessee Practitioners and Providers will allow their performance data to be used for quality improvement activities.

Quality is a significant focus of the Affordable Care Act (ACA). Section 3011, Part S, Subpart 1 describes a National Strategy for Quality Improvement in Health Care. Many of the priorities listed under “Requirements” identified in this portion of the ACA align with the BlueCare Tennessee Quality Improvement Program. Within its scope, BlueCare Tennessee focuses on the following priorities that are listed in the ACA:

- Have the greatest potential for improving the health outcomes, efficiency and patient-oriented health care for all populations, including children and vulnerable populations
- Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques
- Enhance the use of health care data to improve quality, efficiency, transparency and outcomes
- Address health care provided to patients with high-costs chronic diseases
- Reduce health disparities across health disparity populations and geographic areas

Program Approach, Goals and Objectives

Population Health Management

To achieve improvements in population health, Member satisfaction and health care cost efficiency, BlueCare Tennessee implements an approach to population health management that is comprehensive and generally applicable to the overall TennCare population, yet flexible enough to effectively accommodate the needs and circumstances of each of these populations.

BlueCare Tennessee uses the Population Health Management approach as our service delivery model. The Population Health Management model describes a variety of approaches developed to foster health and quality of care improvements while managing costs. It is defined as the ability to assess the health needs of a specific population, implement and evaluate interventions to improve the health of that population and provide care for individual Members in the context of the culture, health status, and health needs of the populations of which that person is a Member. Population Health Management is a way of looking at Members as individuals and as Members of groups with shared health care needs.
The Population Health Management model protects privacy and security of Members according to state and federal laws and regulatory compliance programs. Population Health Management programs are implemented in compliance with BlueCare, TennCare Select, CHOICES, and ECF CHOICES health benefit plans. The effectiveness of the model is measured using relevant Healthcare Effectiveness Data and Information Set (HEDIS®) indicators and other statistically valid outcomes measurements/tools. An analysis of the Population Health Management’s impact is provided as part of the annual program evaluation.

BlueCare Tennessee works to serve our TennCare population. Various lines of business within BlueCare Tennessee manage the care of diverse populations in varied geographies and health care delivery systems. These populations include:

- Children in low income families
- Children in foster care
- Low-income women
- Adults with functional disabilities
- People with severe mental illness
- People with substance use disorders
- Adults with Intellectual disabilities
- Adults with developmental disabilities
- Adults requiring long-term care services

Key clinical and service indicators such as HEDIS rates are used to measure performance and effectiveness of quality improvement initiatives. BlueCare Tennessee HEDIS priorities include the following:

- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:
  - BMI Percentile Documentation
  - Counseling for Nutrition
  - Counseling for Physical Activity
- Childhood Immunization Status
- Well-Child Visits In the First 15 Months of Life
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Use of Appropriate Medication for People with Asthma
- Comprehensive Diabetes Care:
  - Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
    - Eye Exam (Retinal) Performed
    - LDL-C Screening
    - LDL-C Control <100mg
    - Medical Attention for Nephropathy; Nephropathy Screening
    - Blood Pressure Control <140/90
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Follow-Up Care for Children Prescribed ADHD Medication
- Follow-Up After Hospitalization for Mental Illness
- Medical Assistance With Smoking and Tobacco Use Cessation

Cultural and Linguistic Membership Needs
An annual analysis of Members’ race, ethnic origin, gender, and language capacity is conducted in order to assess the organization’s availability of network Practitioners for meeting the racial, ethnic, gender and linguistic needs of its diverse membership.
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In-depth data analyses and collection of population-specific metrics is utilized, which serves as the foundation for a culturally and linguistically diverse membership. The analysis of significant health care disparity in various clinical areas functions as the foundation of BlueCare population health management programs and guides all ethnic, racial, and illness-based disparity reduction efforts. Various data sources are utilized to complete the assessment including enrollment data, US Census data and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data.

The Members’ race and ethnicity data for BlueCare Tennessee is received from the State and entered into lifestyle tables. An internal database has been created which includes information on race and ethnicity for all Members. This database is refreshed monthly with new Member information. Missing race and/or ethnicity information is imputed using an internally developed algorithm relative to the Member’s surname, first name, medical diagnosis, geo-coded race and familial inference.

The Care Management and Outreach Departments utilize the data collected on the five (5) demographic categories (race, ethnicity, gender, primary language, and disability status) to assist with identifying the specific needs of the Members. Data is utilized to identify the geographical location of Members within the demographic categories, providing an opportunity to focus on tailoring education, addressing health care barriers, and developing focused clinical quality improvement activities; thus, improving the cultural disparities facing BlueCare Tennessee’s Members.

Clinical Practice Guidelines (CPGs)
BlueCare Tennessee adopts and disseminates clinical practice guidelines that are relevant to its membership for the provision of preventive and non-preventive health, acute and chronic medical and behavioral health services. These guidelines are intended to assist Practitioners in making appropriate health care decisions for specific clinical circumstances.

BlueCare Tennessee policy and procedure directs that nationally recognized guidelines be utilized when available. All clinical practice guidelines are reviewed at least annually, with more frequent review being initiated if new national standards are published prior to the review date.

Adopted Clinical Practice Guidelines can be viewed online via direct links found in the Health Care Practice Recommendations Manual located on the company website at http://www.bcbst.com/providers/hcpr/.

Paper copies of these guidelines are available upon request by calling 1-888-423-8221.

Goals
The BlueCare Tennessee Quality Improvement Program will ensure:

- Structures and processes are in place to continuously improve the quality of care, safety and appropriateness of services provided to our Members.
- Quality indicators are identified, monitored and evaluated at least quarterly, at a minimum and more frequently as indicated.
- Monitoring and reporting activities are in place to identify trends or issues requiring evaluation and remediation of procedures or processes; targeted strategies developed to improve the identified opportunities for improvement will result in systematic enhancements to the delivery and quality of care (i.e., focus audits, surveys, and tracking of grievances).
- All lines of business within the BlueCare Tennessee division consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards and this Clinical Quality Improvement Program, based on a multi-disciplinary approach to quality improvement.

Objectives

- Promote a cultural transformation of quality within all departments of BlueCare Tennessee;
  - Implement the QI Program in all BlueCare Tennessee areas of business to support continuous quality improvement to implement best practices;
  - Data collection; and
  - Maximize Member and Provider engagement in quality improvement.

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• Implement and maintain BlueCare Tennessee health promotion activities through Provider education and Member outreach programs to improve performance;
• Implement and maintain oversight and/or coordination of BlueCare Tennessee Care Management Programs, including population health management, case management and care coordination (through Provider and Member engagement, education and Member outreach programs as to improve quality performance);
• Ensure licensed Physicians, organizations and other health care Practitioners are qualified to perform clinical services to BlueCare Tennessee Members with impacted networks and or products;
• Provide Practitioners with clinical practice guidelines for the diagnosis, management and/or prevention of selected illnesses;
• Continue innovative Provider engagement strategies to partner with Physician practices in the state of Tennessee to promote improved quality service delivery through Patient Centered Medical Home (PCMH) practice with the goal of delivering better health outcomes and improved Member experience by encouraging self-management of their conditions through shared goals, education and health coaches, Pay for Performance (P4P), Pay for Gaps (P4G), and embedded care coordinators;
• Monitor utilization patterns through cost and utilization reports, evaluating the health status of our membership, financial trends in health care utilization and clinical engagements to identify and address any aberrant operations and develop and implement quality improvement activities;
• Assess quality of care grievances and concerns from all sources;
• Support clinical initiatives and activities related to Consumer Assessment of Healthcare Providers and Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS) effectiveness of care (EOC), and access and availability measures;
• Monitor Provider and Member satisfaction data for opportunities for improvement;
• Review hospital patient safety across Tennessee;
• Comply with all contracts/agreements including the TennCare Contractor Risk Agreement (CRA), TennCareSelect TSA and Centers for Medicare & Medicaid Services (CMS);
• Maintain accreditation through the National Committee for Quality Assurance (NCQA); and
• Comply with the standards and expectations set forth by the accrediting agencies as well as federal and state regulations.

Information about the QIP, the organization's progress toward goals and the organization's performance data will be made available to Members, health plan staff and Providers/Practitioners annually. For more information about the Quality Improvement Program, please call 888-423-8221 or visit the BlueCare Tennessee website Provider page at http://bluecare.bcbst.com/providers.

B. Scope of Responsibility

The BlueCare Tennessee Clinical Quality Improvement (CQI) Department is responsible, in conjunction with the Chief Medical Officer or his designee, for developing, coordinating, and implementing clinical and process quality initiatives for BlueCare Tennessee. Collaboration with and support from other departments within the division, such as Medicaid Operations, Medical Management, Provider, Member and Outreach areas, are vital to achieve quality improvement successes. This includes monitoring and evaluating the quality indicators and appropriateness of care/service, assessing for continuous improvement in monitored quality activities, monitoring Member and Provider satisfaction, and directing initiatives for improvement and evaluating the effectiveness of interventions across the continuum of care to Members.

CQI is the liaison for clinical quality initiatives with the Division of TennCare and collaborates with BlueCare Tennessee leaders and Corporate Quality Management to meet external quality information needs. The Clinical Quality Improvement Department provides operational leadership for BlueCare Tennessee HEDIS interventions, Member/Provider satisfaction surveying, appeals processing, and quality indicator reporting.
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The Clinical Quality Improvement Department works to establish and promote a culture of operational excellence. This is achieved through focus on process efficiency, service delivery, HEDIS and CAHPS. Achieving high quality in these areas will promote that culture of operational excellence. The CQI Department provides leadership for implementation of the comprehensive Quality Improvement Program for BlueCare Tennessee to meet the demographic and epidemiological needs of the population served. CQI conducts the following activities:

- Establishes objectives and annual goals in conjunction with the Chief Medical Officer or his designee;
- Promotes organization-wide understanding, communication, and coordination of the Quality Improvement Program;
- Oversees the BlueCare Tennessee quality monitoring reporting including analyzing validity of quality improvement data/reports from a clinical perspective;
- Provides leadership for the development, implementation, and evaluation of Clinical Quality improvement action plans for clinical quality improvement activities;
- Oversees the Member grievance process across the company;
- Oversees the centralized appeal process across the company;
- Provides leadership Member/Provider satisfaction survey process;
- Oversees Health Employer Data Information Sets (HEDIS) reporting and provides leadership to the development and realization of action plans to achieve target improvement goals;
- Supports the health plans’ External Quality Review Organization (EQRO) state audit processes;
- Oversees and provides leadership for the BlueCare Tennessee Quality Committee Structure;
- Provides organizational leadership to comply with National Committee for Quality Assurance (NCQA) standards, or other accrediting bodies;
- Assures compliance with state and federal quality improvement/assurance requirements;
- Collaborates with BlueCare and External Communication leaders to meet the CQI information needs of customers; and
- Oversees clinical auditing including ensuing evaluations/recommendations for improvement.

CQI supports Population Health Case Management and Utilization Management in both physical and behavioral healthcare. The CQI role in the support of Behavioral Health utilization management involves monitoring the coordination of services between the physical and behavioral healthcare. CQI also supports the BlueCare Tennessee TennCare CHOICES and ECF CHOICES Home and Community-Based Services Program and SelectCommunity.

The coordination of care will be established using a continual process of the assessment of the Member’s physical, behavioral, functional, and psychosocial needs to identify the services necessary to meet needs that have been determined. The coordination and monitoring of needed physical health, behavioral health, and long-term care services will help the Member maintain or improve his/her physical, behavioral or functional abilities and maximize independence.

The scope of the population served by the QIP includes all Members. Participation in QIP activities include, but are not limited to:

- Primary Care Practitioners and Specialty Providers
- Institutional Settings (hospital, skilled nursing facilities, home health agencies, pharmacies and rehabilitation facilities)
- Non-institutional Settings (free-standing surgical centers, urgent care centers, emergency departments, physical therapy, and community mental health agencies)
- Internal Operations
C. Structure

The BlueCare Tennessee QI structure is driven by unique areas within the QI Department under the direction of the Director of Quality Improvement and supported by the BlueCare Tennessee President & Chief Executive Officer and Vice President & Chief Medical Officer. Additional program input is sought through direct collaboration with the Medical Director of DSNP & CHOICES, the Medical Director of Government Medical Management as well as the Director of Population Health Management.

These areas are as follows:

- Quality Improvement
- Clinical Improvement
- Process Improvement
- Appeals
- Quality of Care Oversight

Quality/Clinical Improvement (CI)

Functional areas include:

- Clinical PIPs
  - CI is responsible for the annual submission of clinical PIPs as specified by the Division of TennCare in the BlueCare Tennessee Contractor Risk Agreement (CRA) and TennCare Select Agreement (TSA). Clinical PIPs are documented using the MCO PIP Summary Form and PIP Summary Form Completion Instructions provided by the Division of TennCare.
  - The two (2) contractually required clinical PIPs shall include one (1) in the area of behavioral health. The behavioral health PIP shall be relevant to one of the population health behavioral health management programs for bipolar disorder, major depression, or schizophrenia. The other clinical PIP shall be in the area of maternal or child health.
- HEDIS Improvements
- Accreditation and Regulatory Compliance
- Quality Cultural Transformation/System-wide Focus on Quality
- Quality Committee Coordination and Support
- Research and Submission of Best Practices
- Annual Documents (QI Program Description, QI Program Evaluation, Work plan)
- New Program Design
- Prevention and Wellness

Process Improvement (PI)

The scope of PI focuses on quality improvement within medical management. Quality assurance is a systematic, departmental approach to ensuring a specified standard or level of care. PI is focused on detecting and solving problems. The department uses methods to inspect performance and repair or correct performance if it is below an accepted standard. The emphasis is on identifying outliers and taking steps to bring performance back up to standards. The monitoring of BlueCare Tennessee medical management procedures and process improvement is needed to ensure continuous compliance with both regulatory requirements and accreditation standards.

The goal of PI is to assess key performance indicators and processes, identify, document, and verify that appropriate processes are in place, and to address any potential gaps in the quality of care.

PI works with the business owners to establish workgroups, identify gaps in processes, determine barriers, and develop actions to address identified gaps. PI assists in the development of work plans that include timeframes, responsible parties, and outcomes.
Functional areas of the Process Improvement department include:

- Satisfaction Surveys
- Quality Review Audits
  - Process Audits
  - Focus Audits/Studies
- Focus Improvement Plans (FIPs)/Corrective Action Plans (CAPs)
- Medical Director and Nurse Inter-Rater Reliability (IRR) Process
- Policy/Procedure Coordination
- Regulatory and Accreditation Compliance

The QI Department collaborates with all departments within BlueCare Tennessee to identify, monitor and evaluate quality indicators. Quality indicators and/or quality improvement activities are reported to the appropriate oversight committees at least quarterly and include, but are not limited to:

- Compliance audits
- Compliance of telephone performance against established standards
- Member participation in population health programs, such as complex case management or chronic care management
- Annual review and/or update of policies and procedures
- Annual review of criteria used to assist in medical necessity determinations
- Grievance and appeals data and resolution
- HEDIS clinical quality indicators
- Adverse incidents/Critical Incidents
- Health Outcomes Survey
- Member and Provider Satisfaction

While Clinical Quality Management drives the Quality Improvement Program for BlueCare Tennessee, many departments within the division have staff dedicated to quality improvement. For example, CHOICES/ECF CHOICES has a Manager of LTSS Compliance with a team devoted to compliance within that area.

BlueCare Tennessee implements Provider engagement strategies to improve both Provider and Member experiences through initiatives such as:

- Patient Centered Medical Home
- Pay for Performance
- Pay for Gaps
- Embedded Care Coordination

Committee Structure

The QI Department is responsible to provide leadership for the communication of quality improvement activities and outcomes. This information is communicated to both executives and staff through vertical and horizontal communication strategies as outlined in the BlueCare Tennessee committee structure.

BlueCare Tennessee Quality & Operational Oversight Committee (BCQOC)

The function of the BCQOC is to implement the BlueCare Tennessee QI Program, overseeing BlueCare Tennessee’s accreditation, contract and regulatory compliance via horizontal and vertical communication among the various departments and divisions.
This Committee has oversight over:

- Population Health Improvement Committee
- Integrated Population Health Oversight Committee
- Member Services Committee
- SelectCommunity, Disabilities
- Disparities Advisory Panel
- BlueCare Plus (HMO SNP)SM Quality Committee
- Cover Tennessee Operations Committee

The BCQOC has been delegated by BlueCare Tennessee’s Board of Directors to provide oversight of the Quality Improvement Program and thus recommend approval of all related Quality Improvement annual documents.

**Program Evaluation and Work Plan**

The overall effectiveness of the QI Program is evaluated at least quarterly and documented in a detailed work plan and an annual summary/evaluation. The evaluation and work plan address:

- Progress and status of goals
- Completed and ongoing quality improvement (QI) activities
- QI activities initiated throughout the year
- Trending of clinical, service and other performance measures
- Analysis of results for demonstrated improvement in quality
- Identified opportunities for improvement
- Overall effectiveness of the QI Program
- Goals and recommendations for the work plan for the following year

Policies and procedures supporting the QI Program are reviewed and approved annually by the appropriate committee or department head and updated as needed.

Based on the annual program evaluation, the CQI Program is revised and a QI work plan is developed. The purpose of the annual work plan is to focus on QM Program goals, objectives, and planned projects/activities for the forthcoming year. The annual work plan also identifies person(s) responsible for different portions of the work plan and timeframes for achievement of activities and committee reporting. The work plan is utilized as an action plan to document the status of activities and achievement of goals throughout the year. It is updated at least quarterly and submitted to the Quality Oversight Committee for review, comments, and recommendations for revisions.

The annual evaluation, work plan, and program description are approved by the BlueCare Tennessee Quality Oversight Committee for implementation with final approval and endorsement by the Board of Directors. These documents are submitted to the Division of TennCare for review. Information about the QI Program, the organization’s progress toward goals, and the organization’s performance data is made available to Members, health plan staff and Practitioners on an annual basis via the Member and Provider newsletters.

Provider data is shared with Providers through various quality initiatives. For example, the Breast Cancer Screening and Use of Imaging for Low Back Pain workgroups have shared HEDIS rates with individual Providers to promote improved adherence to professional recommendations and/or evidence-based clinical guidelines.

Data is available to Providers and Members through public information sources such as Comparative Analysis of Audited Results from TennCare MCOs published on the TennCare website at [https://www.tn.gov/content/dam/tn/tenncare/documents/hedis16.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/hedis16.pdf).

The National Association for Quality Assurance also publishes information on the health plan at [https://reportcards.ncqa.org](https://reportcards.ncqa.org).
Confidentiality and Conflict of Interest

BlueCare Tennessee, as a subsidiary of BlueCross BlueShield of Tennessee, is compliant with all standards and rules set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). BlueCare Tennessee relies on the “minimum necessary and reasonable” rule. Minimum necessary is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. Efforts regarding confidentiality are ongoing to ensure the security of Member identifiable information related to Quality Improvement Initiatives.

No person may participate in the review and evaluation of any case or issue in which he or she has been personally or professionally involved or where a conflict of interest may exist, which potentially compromises objective evaluation.

Discriminatory Practices

No person on the grounds of race, color, national origin, language, sex, age, religion or disability, or any other classifications protected under federal or state laws shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by BlueCross BlueShield of Tennessee or subsidiaries, such as BlueCare Tennessee.

To better meet the needs of our customers, BlueCare Tennessee offers Spanish-speaking Member communication materials for those who speak Spanish. In addition, in an effort to assist our disabled BlueCare and TennCare Select populations, key Member materials are available for the blind, including Braille, large print and compact disks (CDs).

Home Health Critical Incidents

Delivering quality care to our Members and ensuring their safety and well-being takes everyone’s commitment. If you are a Home Health Provider, reporting critical incidents is required by the Contractor Risk Agreement 2.15.7.3. A Home Health Critical Incident includes all significant critical incidents that occur during the provision of home health services involving BlueCare Tennessee and/or CoverKids Members. This includes CHOICES, ECF CHOICES and non-CHOICES/ECF CHOICES Members receiving home health services.

These incidents include, but are not limited to:

- Death
  - Any unexpected death, regardless of whether the death occurs during the provision of home health services
- Major/Severe Injury
  - An injury that requires assessment and treatment beyond basic first aid that can be administered by a lay person (broken bones, wounds, decubitus ulcers and sutures)
- Safety Issues
  - Falls
  - Home health agency staff operating outside scope of practice and/or plan of care
- Suspected physical, mental, or sexual abuse
  - Infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish
- Neglect
  - A lack of care that could potentially lead to harm of the Member
- Life-threatening medical emergency
  - Member’s condition is cause for emergency medical treatment, such as by ambulance (heart attack or stroke)
- Medication Error
  - Incorrect drug, person, time, dose, rate, preparation or route of administration
Financial Exploitation
- Unauthorized, improper or failure to use the Member’s funds, property or other resources according to the Member’s desires or well-being

Thief
- Any reported theft of property, medication, or money from a Member

Each incident must be reported to BlueCare as quickly as possible upon discovery using the *Home Health Agency Critical Incident Reporting* form located online at: [https://bluecare.bcbst.com/providers/forms.html](https://bluecare.bcbst.com/providers/forms.html).

The completed form should be submitted to:

BlueCare Quality of Care Oversight Department  
Fax: 1-855-339-3022  
e-mail: BlueCareQOC@bcbst.com

A staff member of the BlueCare Quality of Care Oversight department will be in contact regarding any additional documentation that is needed.

Home Health Agencies should continue to follow current processes for APS/CPS reporting in addition to Home Health Critical Incident reporting to BlueCare.

Questions may be submitted in writing to the fax number above or call one of the numbers below:

BlueCare 1-800-468-9736  
TennCareSelect 1-800-276-1978  
CoverKids 1-800-924-7141

**Death of Member**

All unexpected deaths of BlueCare Tennessee or CoverKids Members must be reported to BlueCare Tennessee upon discovery. An investigation into the death will be conducted by the BlueCare Quality of Care Oversight Department in order to assist in identification of gaps in Member’s care that may have contributed to their death.

Each death must be reported to BlueCare Tennessee as quickly as possible upon discovery using the *Death of Member Notification Form* located online at [https://bluecare.bcbst.com/providers/forms.html](https://bluecare.bcbst.com/providers/forms.html).

The completed form should be submitted to:

BlueCare Quality of Care Oversight Department  
Fax: 1-855-339-3022  
e-mail: BlueCareQOC@bcbst.com

A staff member of the BlueCare Quality of Care Oversight department will be in contact regarding any additional documentation that is needed.

Questions may be submitted in writing to the fax number above or call one of the numbers below:

BlueCare 1-800-468-9736  
TennCareSelect 1-800-276-1978  
CoverKids 1-800-924-7141
D. Medical Management Corrective Action Plan (MMCAP)

PURPOSE: This procedure statement outlines how BlueCross BlueShield of Tennessee, Inc., and its affiliated companies, ("the Plan") may initiate corrective actions if a participating Provider fails to comply with applicable medical management requirements set forth in section 1, below. This statement also outlines how the Plan will process denials of initial applications. The Plan’s medical management programs include Provider credentialing, utilization review, quality management and Member grievance resolution activities that are overseen by professional review committees. The Plan's Board of Directors has designated the Quality Oversight Committee and its subcommittees (the "Committees") as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-6-219 and other applicable laws governing the organization and operation of professional peer review or medical review committees (the "Peer Review Laws").

The Plan's staff has been authorized to provide necessary support services to the Committees. Members of the Board, Committee Members, staff Members and anyone providing information to those Committees are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this Procedure statement have been incorporated by reference into the Plan's Provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating Provider and, if applicable, selected to participate in the Plan, participating Providers agree that they shall not seek to hold the Plan or such individuals liable for acts taken in good faith in accordance with this Procedure statement.

This procedure only applies to matters that involve Committee actions. Matters that do not involve Committee actions include: the non-acceptance of a participation application because the Provider fails to satisfy the Plan's pre-credentialing application standards (e.g. failure to provide evidence of licensure or insurance), the termination of a Provider's participation other than by reason of that Provider's failure to comply with applicable participation requirements (e.g. the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the Plan's Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the Committees shall be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the Committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement shall not alter the status of such records or information as privileged and confidential information.

I. PARTICIPATION REQUIREMENTS

The Plan's Chief Medical Officer or his designee (the "Chief Medical Officer") will monitor participating Providers' performance to ensure that they comply with the Plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

A. Participating Providers shall cooperate, in good faith, to facilitate the Plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the Plan, providing information and documents requested by the Plan and cooperating with Plan staff Members as they perform their medical management activities.

B. Participating Providers shall render or order Medically Necessary and Appropriate services for Member-patients.

C. Participating Providers shall obtain prior authorization of services in accordance with applicable Plan medical management program policies and procedures.

D. Participating Providers shall comply with accepted professional standards of care, conduct and competence.
E. Participating Providers shall continue to satisfy the Plan's credentialing requirements as set forth in the Plan’s Credential Process, including, without limitation:

1. The Provider's licenses or certifications must be in good standing.
2. The Provider's liability insurance coverage must remain in full force and effect.
3. There have been no unreported material changes in the Provider's status such that the credentialing information submitted to the Plan is no longer accurate.

II. CORRECTIVE ACTIONS

A. INVESTIGATION

The Plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or his designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the Plan. Staff members or the Chief Medical Officer may, at their discretion:

1. Consult with the Provider;
2. Review material documents, including Members' medical records; or
3. Contact other Providers or persons who have knowledge concerning the matter being investigated.

B. BASIS OF ACTIONS

The Chief Medical Officer or a Committee may initiate a corrective action if a participating Provider does not comply with applicable participation requirements, and:

1. There is a reasonable belief that the action will promote the objectives of the Plan’s medical management program.
2. There has been a reasonable effort to obtain the facts concerning the Provider's alleged non-compliance.
3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

C. ACTIONS BY THE CHIEF MEDICAL OFFICER

Upon determining that a participating Provider has not complied with the Plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

1. Counseling the Provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the Provider’s credentialing file.
2. Submitting information regarding the Provider's conduct to the appropriate Committee for further consideration and action.
3. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:
   a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, closure of the Provider's practice to new Members, and/or imposition of a practice improvement plan.
   b. Terminating the Provider's participation.
   c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g. the cost of services incurred as a consequence of the Provider’s non-compliance) or the denial of fees for inappropriate or unauthorized services.
4. Imposing a summary suspension. The Chief Medical Officer shall notify the Provider, by certified mail, of the summary suspension of the Provider's participation, if such action is necessary to protect Members' health and welfare or to protect the Plan's reputation or operations.

a. If the Chief Medical Officer or a Committee requires additional time to investigate allegations concerning a Provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within fourteen (14) days after the imposition of the summary suspension.

b. If, after such investigation, it is determined that the Provider's conduct, competence, practices or reputation may result in an imminent danger to Members' health or welfare, or impair the Plan's reputation or operations, the suspension shall continue in effect unless the Provider's participation is reinstated following a hearing conducted in accordance with section III, below.

c. The Chief Medical Officer shall make appropriate arrangements to have other Providers render services to Members who are under the care of the suspended Provider. The suspended Provider shall cooperate in referring Members to such other Providers in accordance with this Corrective Action Plan and the terms of his or her participation agreement.

d. If a Provider is a member of a medical group or IPA, the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

D. ACTIONS BY THE COMMITTEE

1. Committee Meetings

If the Chief Medical Officer refers the matter to a Committee, that Committee shall consider information submitted to it concerning a Provider's non-compliance with the Plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider that matter. Members of the Committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a Committee concerning a Provider's alleged non-compliance shall be conducted in confidence and any information concerning such meetings shall be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

2. Committee Investigations

A Committee may direct the Chief Medical Officer or his designee to further investigate and submit additional information concerning a Provider's alleged non-compliance. The Committee may also request that the Provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The Provider otherwise has no right to participate in Committee proceedings.

3. Corrective Actions

The Committee may request the Chief Medical Officer to take any of the corrective actions described in section II.C, above. In addition, the Committee may take any of the Corrective Actions described in section II.C above except for II.C.4 (imposing a summary suspension). The Credentialing Committee may deny or revoke a Provider's Credentials.

E. NOTICE OF CORRECTIVE ACTION

The Chief Medical Officer or the Chairperson of the Committee shall immediately notify the Provider, by certified or overnight mail, of the imposition of a corrective action. If the Provider is a member of an IPA or medical group, a copy of that notice shall also be sent to the Medical Director of that IPA or medical group. That corrective action shall become effective as of the date of that letter, unless the Chief Medical Officer or Committee elect to defer the effective date of that action.
The notice letter shall include:

1. A description of the corrective action,
2. A general description of the basis of that action,
3. A statement explaining how to request an appeal to the imposition of that action (to the extent that action is subject to appeal), specifying that such an appeal must be requested within thirty (30) days after the date of that notice letter.
4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the Provider doesn’t request an appeal or if that action is affirmed following exhaustion of the appeal process.

III. APPEAL PROCEDURES

A. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER

1. Written Appeal
   a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer imposing the corrective action. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
   b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.

2. Informal Subcommittee Meeting
   a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
   b. If an informal subcommittee is granted, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.
   c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

3. Binding Arbitration
   a. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan’s response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted...
by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

b. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then claimant forfeits its filing fee and it may not be assessed against BCBST.

c. Each party shall be responsible for one-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.

d. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider’s participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction.  The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Administration Manual.

B. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT

1. Written Appeal

   a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

2. Binding Arbitration

   a. If the Provider is still not satisfied with the Committee’s decision, he may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section III.A.3 above.

C. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS

1. Informal Subcommittee Meeting

   a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the
Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.

b. If there is an informal subcommittee meeting, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.

c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee’s recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee’s recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee’s deliberations concerning the subcommittee’s recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

2. Hearing

a. Appointment of the Hearing Officer

The Provider may request a hearing regardless of whether or not there was an informal subcommittee meeting. In that event, the Chief Medical Officer shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
2. May not be in direct economic competition with the Provider requesting the hearing.
4. Shall be acting as member of the Committee while performing his or her duties.

b. Notice of Hearing

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a detailed description of the basis of the corrective action, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing
without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.

2. The hearing will be recorded by a court reporter.

3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.

4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.

5. During the hearing, each party has the right to:
   i. call witnesses,
   ii. cross-examine opposing witnesses, and
   iii. submit a written statement at the close of the hearings

6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer's report and recommendation.

d. Hearing Officer’s Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee’s decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws.

f. Appeal of Decision

Any action based upon or related to the Committee's decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.
IV. REPORTING CORRECTIVE ACTIONS

A. REPORTING TO REGULATORY AGENCIES

Certain actions must be reported in accordance with both state and federal law, including without limitation, the National Practitioner Data Bank (NPDB). The Chief Medical Officer will consult with the Plan's General Counsel prior to initiating any corrective action, if there is a question concerning whether it will be a reportable action.

1. The following actions must generally be reported:
   a. All professional review actions adversely affecting a Provider's participation in the Plan for longer than thirty (30) days based upon the Provider's professional conduct or competence.
   b. Acceptance of a voluntary termination of the Provider's participation while the Plan is investigating the Provider's conduct or competence, if that termination is intended to avoid the imposition of reportable sanctions.
   c. A summary suspension that remains in effect for longer than fourteen (14) days.

2. Reports required by federal or state law, including without limitation the NPDB, must include:
   a. the name of the Provider,
   b. a description of the facts and circumstances that form the basis for that action, and
   c. any other relevant information requested by that licensing board.

3. The following actions are generally not reportable:
   a. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.
   b. Actions based upon the Provider's failure to comply with participation requirements that are not directly related to the Provider's professional conduct or competence.

B. INTERNAL REPORTING REQUIREMENTS

All corrective actions whether reportable to a licensing board or not, must be reported to the following persons:

1. The involved Provider.
2. The Plan's General Counsel.
3. The Plan's Provider Networks and Contracting Department.
4. The Medical Director of each participating Medical Group or IPA if the Provider is a member of that entity.
XII. Highlights of Provider Agreement

All BlueCare, TennCareSelect and CoverKids network Providers have signed a “Provider Agreement” with Volunteer State Health Plan, Inc., dba BlueCare Tennessee. The Provider Agreement contains the provisions that govern the relationship between BlueCare Tennessee and the Provider under the BlueCare, TennCareSelect and CoverKids plans.

Monthly Screening Requirements

For the purpose of the Monthly Screening Requirements, the following definitions shall apply:

“Exclusion Lists” means the U.S. Department of Health and Human Services’ Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) and the General Services Administration’s (GSA) System for Award Management (SAM). For Subcontractors, in addition to the forgoing, the definition of “Exclusion Lists” also includes the Social Security Master Death File (“MDF”).

“Ineligible Persons” means any individual or entity who: (a) is, as of the date such Exclusion Lists are accessed by the Provider, excluded, debarred, suspended or otherwise ineligible to participate in federal healthcare programs or in federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. §1320(a)-7(a), but has not yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their monthly obligation to screen all employees and contractors (the “Monthly Screening Process”) against the Exclusion Lists to determine whether any of them have been determined to be ineligible Persons, and therefore, excluded from participation as a Medicaid Provider. Providers are also required to have employees and contractors disclose whether they are Ineligible Persons prior to providing any services on behalf of the Provider. The Monthly Screening Process is a Centers for Medicare & Medicaid Services (CMS) requirement and a condition of their enrollment as a BlueCare Tennessee Medicaid Provider and is also a continuing obligation during their term as such. The word “contractors” in this section refers to all individuals listed on the disclosure form including Providers and non-Providers such as board members, owners, agents, managing employees, etc.

Providers, whether contract or non-contract, and Subcontractors shall comply with all federal requirements (42 CFR §1002) on exclusion and debarment screening. Subcontractors and all tax-reporting Provider entities that bill and/or receive TennCare funds as a result of the Agreement shall screen their owners and employees against the Exclusion Lists. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or recouped by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.

Medicaid Providers must immediately report any exclusion information discovered to their contracted managed care organization. (See Section I. Introduction of this Manual for a listing of appropriate contact numbers.)

If Provider determines that an employee or contractor is or has become an Ineligible Person, Provider will take the appropriate action to remove such employee or contractor from responsibility for, or involvement with Provider’s operations related to federal healthcare programs. In such event, the Provider shall take all appropriate actions to ensure that the responsibilities of such employee or contractor have not and will not adversely affect the quality of care rendered to any BlueCare Tennessee Member of any federal healthcare program.

Participating or Plan Providers

“Participating” or “Plan” Providers are those who have signed an agreement with BlueCare Tennessee to provide Covered Services to our BlueCare, TennCareSelect and/or CoverKids Members.
Covered Services
Covered Services are the physical health services, behavioral health services, and long-term services and supports a Member is entitled to receive under the terms of his or her plan. The specific services that are included under the BlueCare, TennCare Select and CoverKids plans are outlined under the Benefits section of this Manual. For a service to be reimbursed, BlueCare Tennessee must consider it Medically Necessary.

Behavioral Health Crisis Services
Crisis, crisis respite, crisis stabilization, and mobile crisis services are provided for BlueCare Tennessee Members. See Chapter XV. Behavioral Health Services in this Manual for more information. See Chapter X. Population Health Management Program in this Manual for arranging services for TennCare Select Members.

TennCare Kids Covered Services
Providers are required to make treatment decisions based upon children’s individual medical and behavioral needs. See Chapter XX. TennCare Kids of this Manual for the package of Benefits that TennCare Kids offers.

Non-Medically Necessary Services
Members may not be billed for services that BlueCare Tennessee does not consider Medically Necessary.

Keeping Medical Documentation
Providers are required to maintain clinical records for each Member in accordance with the standards of the medical profession, the Medical Record Standards as stated in the Credentialing section of this Manual, and any licensure and accreditation requirements. Providers are also required to supply to BlueCare Tennessee, its agents, or representatives, promptly and without cost, any records or documentation requested for claims adjudication, utilization management, medical review, authorized research, on-site audits, or regulatory compliance purposes.

Claim Filing Limits
Providers are required to submit accurate and complete claims within 120 days of the date of service, or for facilities, within 120 days from the date of discharge.

Late Claims
BlueCare Tennessee will not honor claims submitted after the 120-day filing limit, unless Providers submit documentation to justify their failure to submit the claim within 120 days.

Billing Restrictions
Providers may not bill a Member for services that were denied based on late claims submission. Providers may not demand full payment up front from a Member for providing Covered Services, but may collect any applicable co-pay or co-insurance amount due. Neither may a Provider refuse services to a Member that has been involved in an automobile accident in order to avoid billing and collection of the network rates for such services. In no event may Providers bill the Member for denied services.

Billing For Denied Out-of-Network Referrals
If denial is based on a referral or determination that there was no referral on file, the Provider may not bill the Member or Plan for services.

Coverage
Primary Care Practitioners (PCPs) agree to maintain appointment hours that are convenient to Members and to have 24-hour emergency and on-call services they provide directly or through arrangements made with a Participating Plan PCP.

Provision of Care
PCPs agree to provide or manage all health care services for the Members assigned to them and to refer the Members to other participating BlueCare, TennCare Select Providers. The Provider shall not be required to accept or continue treatment of a Member with whom the Provider feels he/she cannot establish and/or maintain a professional relationship. Neither PCPs nor Specialists are obligated to provide care if a Member refuses to follow the prescribed course of treatment. In these circumstances, refer the case to the medical director. (Specifics of the care to be provided by PCPs can be found in Section VI. Primary Care Provider of this Manual).
Plan Covered By Agreement  
The Health Maintenance Organization contract applies to our BlueCare plan.

Provider Appeal Procedures  
If any dispute arises between the parties that either party has failed to perform its obligations and responsibilities under the Provider Agreement or this Manual, then either party shall initiate a dispute in accordance with the Provider Dispute Resolution Procedure set forth in this Manual (the “Provider Dispute Resolution Procedure”) other than the Independent Review Process set forth below.

In addition to the above process, Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve claims denied in whole or in part by BlueCare Tennessee, as provided in Tenn. Code Ann. §56-32-126. It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by Tenn. Code Ann. §56-32-126.

The Request to Commissioner of Commerce for Independent Review of Disputed TennCare Claim form is located on the state’s website at https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/forms/INDEPENDENT_REVIEW_COMPLAINT_FORM_1.7.16.pdf. Additional information regarding the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance are also available online at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html.

A. Administrative Inquiry

1. Administrative Inquiry Description  
Providers can submit Administrative Inquiries for review of non-clinical information about services already rendered, such as claims adjustments. Since these inquiries are claims-oriented in nature, they may be submitted to the appropriate Regional Customer Service Center. Administrative Inquiries may be requested for the following reasons:

- The claim for services does not adequately fit a related CPT® code or local code description due to unique circumstances.
- BlueCare Tennessee denied payment because it isn’t available in the Member’s coverage.
- A PCP or network Practitioner failed to obtain a referral or authorization for services that required them.
- Retroactive referrals.

2. How to submit administrative inquiries  
Providers may submit an Administrative Inquiry by calling the appropriate Provider Service Line or by sending the request in writing to the appropriate Regional Customer Service Center. (Please refer to the Appeals Quick Reference Guide located in Section I. of this Manual for a listing of phone numbers and addresses.)

Exhausting the above noted processes satisfies Section II. A and B. of the Provider Dispute Resolution Procedure (PDRP) located in this section of the Manual. If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. C. of the PDRP.
B. Provider Dispute Resolution Procedure

PURPOSE: To address and resolve any and all matters causing participating Providers ("Providers") or BlueCare Tennessee or its affiliated companies to be dissatisfied with any aspect of their relationship with the other party (a "Dispute"). Providers are encouraged to contact a representative of BlueCare Tennessee's Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

*Non-contracted, non-participating, and out-of-state Providers may also utilize the PDRP pursuant to the terms hereof and in accordance with BlueCare Tennessee policy.

I. INTRODUCTION.

A. This Procedure describes the exclusive method of resolving any Disputes related to a Provider's participation in BlueCare Tennessee's network(s). It is incorporated by reference into the participation agreement between the parties (the "Participation Agreement") and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BlueCare Tennessee's or the Provider's control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party's control (e.g., determinations made by a customer purchasing administrative services only ("ASO Customers") from BlueCare Tennessee).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant's professional qualifications, conduct or competence must be resolved pursuant to BlueCross BlueShield of Tennessee's "Medical Management Corrective Action Plan" (Section XI.D). Note: BlueCare Tennessee uses BlueCross BlueShield of Tennessee’s Medical Management Corrective Action Plan.

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for Reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g., the date of the letter informing the Provider of a determination) or, with respect to a Provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the Provider received payment or, in the event of unpaid claim, the date the Provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BlueCare Tennessee pursuant to applicable provisions of the Provider’s agreement(s) with BlueCare Tennessee, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BlueCare Tennessee discovers a matter creating a Dispute with a Participating Provider during an audit which is in progress at the end of the
eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

H. **ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES’ SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.**

II. **DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.**

A. **INQUIRY/RECONSIDERATION.**

Providers should contact a representative of the BlueCare Tennessee division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g., the Claims Service Department if there is a question concerning a claims-related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BlueCare Tennessee representative. BlueCare Tennessee may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g., an office manager). If a party cannot respond immediately to the other party’s inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. **APPEAL.**

If not satisfied, a party may submit a written appeal within sixty (60) days after receiving the other party’s response to its inquiry/Reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/Reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. **BINDING ARBITRATION.**

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within sixty (60) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.

The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BlueCare Tennessee.
The arbitrators shall consider each claimant’s demand individually and shall not certify or consider multiple claimants’ demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider’s Participation Agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

Notices for arbitration should be sent to:

BlueCross BlueShield of Tennessee, Inc. (or BlueCare Tennessee)
Attention: General Counsel
1 Cameron Hill Circle
Chattanooga, TN 37402

D. EFFECTIVE DATE.
This procedure statement was adopted by BlueCare Tennessee on June 1, 1997.

Last date of revision, April 1, 2018.

Note: The former Provider Dispute Form has been replaced with the following fillable forms located on BlueCare Tennessee website:

Provider Reconsideration Form
http://bluecare.bcbst.com/forms/Provider%20Forms/ProviderReconsiderationForm16PED988.pdf

Provider Appeal Form
http://bluecare.bcbst.com/forms/Provider%20Forms/ProviderAppealForm16PED987.pdf

Additional information on Reconsideration and appeals processes can be found on the Provider Page on BlueCare Tennessee website, http://bluecare.bcbst.com/.

C. TennCare Provider Agreement Requirements

The TENNCARE Contractor Risk Agreement and the Agreement for the Administration of TennCareSelect (collectively the “Agreement”) between TENNCARE and BlueCare Tennessee (also referred to herein as “MCO”) specify the following MCO, Provider and Provider Agreement requirements, all of which are hereby incorporated by reference into the BlueCare Tennessee TENNCARE Provider Agreements.

In addition, if a Subcontract is for the purposes of providing or securing the provision of Covered Services to TennCare Enrollees, the MCO shall ensure that all Provider Agreement requirements described below as well as the required Subcontract requirements indicated in Section A.2.26 of the
Agreement are included in the Subcontract and/or a separate Provider Agreement executed by the appropriate parties.

*For Definitions pertaining to this section, please see the Definition page at the end of this Section.*

1. All Provider Agreements shall be in writing. All new Provider Agreements and existing Provider Agreements as they are renewed, must include a signature page, which contains MCO and Provider names, which are typed or legibly written, Provider company with titles, and dated signatures of all appropriate parties. Signed agreements may include a wet or handwritten signature or valid binding electronic signature as required by BlueCare Tennessee. Agreements kept on file in an electronic format must be immediately accessible in a printable version upon request by TennCare or any authorized party as described in Section A.2.12.9 of the Agreement.

2. For any entities to which BlueCare Tennessee makes payment via electronic transfers, BlueCare Tennessee shall have a signed Electronic Funds Transfer (EFT) form as part of the overall Provider Agreement. The signed EFT form shall have 42 CFR §455.18 and §455.19 statements immediately preceding the “Signature” section.

3. All Provider Agreements shall specify the effective dates of the Provider Agreement.

4. The Provider Agreement and its attachments shall contain all the terms and conditions agreed upon by the parties.

5. Failure by the Provider to obtain written approval from the MCO for a Subcontract that is for the purpose of providing TennCare Covered Services may lead to the contract being declared null and void at the option of TENNCARE. Claims submitted by the Subcontractor or by the Provider for services furnished by the Subcontractor are considered to be improper payments and may be considered false claims. Any such improper payments may be subject to action under federal and state false claims statutes or be subject to be recouped by the MCO and/or TENNCARE, as overpayments.

6. The Provider Agreement shall identify the population covered by the Provider Agreement.

7. The Provider may not refuse to provide covered Medically Necessary or covered preventive services to a child under the age of twenty-one (21) or a TENNCARE Medicaid patient under the Agreement for non-medical reasons. However, the Provider shall not be required to accept or continue treatment of a patient with whom the Provider feels he/she cannot establish and/or maintain a professional relationship.

8. The Provider Agreement shall specify the functions and/or services to be provided by the Provider and assure that the functions and/or services to be provided are within the scope of his/her professional/technical practice.

9. The Provider Agreement shall specify the amount, duration and scope of services to be provided by the Provider and inform the Provider of TENNCARE non-Covered Services as described in Section A.2.10 of the Agreement and the TENNCARE rules and regulations.

10. Emergency Services shall be rendered without the requirement of prior authorization of any kind.

11. Provider shall comply with applicable access requirements, including but not limited to appointment and wait times as referenced in Section A.2.11 of the MCO’s Agreement with TennCare and the applicable federal requirements.

12. Unreasonable delay in providing care to a pregnant Member seeking prenatal care shall be considered a material breach of the network Provider’s contract with the MCO. Unreasonable delay in care for pregnant Enrollees shall mean failure of the prenatal care Provider to meet the accessibility requirements required in Sections A. 2.7.5.2.3 and A.2.11.4 of the Agreement.
13. If the Provider performs laboratory services, the Provider must meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

14. Provider shall have and maintain documentation necessary to demonstrate that Covered Services were provided in compliance with state and federal requirements. Paper records must be signed by the rendering Provider; electronic records must have the capability of affixing an electronic signature to the notes added by the rendering Provider.

15. Provider shall maintain an adequate record system and all records shall be maintained for ten (10) years from the termination of the Provider Agreement or retained until all evaluations, audits, reviews or investigations or prosecutions are completed for recording Enrollee services, servicing Providers, charges, dates and all other commonly accepted information elements for services rendered to Enrollees pursuant to the Provider Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Provider Agreement and administrative, civil or criminal investigations and prosecutions).

16. As a condition of participation in TENNCARE, Enrollees and Provider shall give TENNCARE or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as the Office of Inspector General (TN OIG), Tennessee Bureau of Investigation, Medicare Fraud Control Unit (TBI MFCU), Department of Health and Human Services Office of Inspector General (DHHS OIG), Department of Justice (DOJ), and any other authorized state or federal agency, access to their records.

17. Said records shall be made available and furnished immediately upon request by the Provider in either paper or electronic form, at no cost to the requesting agency, for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions upon the request of an authorized representative of the MCO, TENNCARE or authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to the TN OIG, the TBI MFCU, the DHHS OIG and the DOJ. Said records are to be provided by the Provider at no cost to the requesting agency.

18. Provider shall maintain medical records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. As applicable, medical records are to be maintained or available at the site where medical services are provided for each Enrollee.


20. Behavioral health Providers shall maintain medical records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or Tenn. Code Ann. §33-3-103, whichever is more stringent.

21. MCO, Provider, and any Subcontractor shall ensure that TENNCARE representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TENNCARE, the TN OIG, the TBI MFCU, the DHHS, DHHS OIG, and the DOJ, and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to the medical care or services provided to TENNCARE Enrollees. Access will be either through on-site review of records or through the mail at the government agency’s discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. All records to be sent by mail will be sent to TENNCARE within twenty (20) working days of request unless otherwise specified by TENNCARE or TennCare rules and regulations. Requested records shall be provided at no expense to TENNCARE, authorized federal, state and Comptroller of the Treasury personnel, including representatives from the TN OIG, the TBI MFCU, DOJ and the DHHS OIG, or any duly authorized state or federal agency. Records related to appeals shall be forwarded within the time frames specified in the appeals process portions of the Agreement (Section A.2.19). Such requests made by TENNCARE shall not be unreasonable.
22. MCO, Provider, Subcontractors and other entities receiving monies originating by or through TENNCARE shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to the Agreement as well as medical information relating to the individual Enrollees as required for the purposes of audit or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in Section A.2.20, Fraud and Abuse, of the Agreement. Records other than medical records may be kept in an original paper state or preserved on micromedia or electronic format. Medical records shall be maintained in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc. shall be available for any authorized federal, state, including, but not limited to TENNCARE, TN OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Provider Agreement period and ten (10) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the Provider Agreement period, these records shall be available at the MCO’s chosen location in Tennessee subject to the written approval of TENNCARE. If the records need to be sent to TENNCARE, the Provider or Subcontractor shall bear the expense of delivery. Prior approval of the disposition of MCO, Subcontractor or Provider records must be requested and approved by TENNCARE in writing. Nothing in this section shall be construed to modify or change the obligations of the MCO contained in Section A.2.23.2 (Data and Document Management Requirements), Section A.2.23.3 (System and Data Integration Requirements), or Section A.2.23.6 (Security and Information Security and Access Management Requirements) of the Agreement.

23. TENNCARE, DHHS OIG, Office of the Comptroller of the Treasury, TN OIG, TBI MFCU, and DOJ, as well as any authorized state or federal agency or entity shall have the right to evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means, any records pertinent to the Agreement including, but not limited to medical records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of the Provider. Such records are to be provided at no charge to the requesting agency. Upon request, the Provider shall assist in such reviews including the provision of complete copies of medical records. HIPAA does not bar disclosure of Personal Health Information (“PHI”) to health oversight agencies, including, but not limited to, TN OIG, TBI MFCU, DHHS OIG and DOJ. Any authorized state or federal agency or entity, including, but not limited to TENNCARE, TN OIG, TBI MFCU, DHHS OIG, DOJ, Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions.

24. The Provider is subject to monitoring, whether announced or unannounced, of services rendered to Members.

25. The Provider shall provide for the participation and cooperation in any internal and external QM/QI monitoring, utilization review, peer review and/or appeal procedures established by the MCO and/or TENNCARE.

26. MCO shall provide the participating Provider with a copy of the Member handbook and Provider handbook via the MCO’s website, http://bluecare.bcbst.com or other means, as determined by MCO. MCO shall notify Provider, as determined by MCO, of any denied authorizations.

27. The MCO shall monitor the quality of services delivered under the Provider Agreement and initiate corrective action where necessary to improve quality of care, in accordance with that level of medical care, behavioral health care, or long-term services and supports which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by TENNCARE.
28. The Provider shall comply with corrective action plans initiated by the MCO.

29. The Provider shall promptly submit all reports and clinical information requested by MCO.

30. The Provider’s name and address on the signature shall be the official payee to whom payment shall be made.

31. The Provider Agreement shall make full disclosure of the method and amount of compensation or other consideration to be received from the MCO. However, the Provider Agreement shall not include rate methodology that provides for an automatic increase in rates.

32. MCO shall only pay Provider for services (1) provided in accordance with the requirements of the Agreement, the MCO’s policies and procedure implementing the Agreement, and state and federal law and (2) provided to TennCare Enrollees who are enrolled with the MCO. Provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service.

33. The Provider shall promptly submit information needed to make payment. The Provider shall have one hundred and twenty (120) calendar days from the date of rendering a Covered Service to file a claim with the MCO except in situations regarding coordination of benefits or subrogation in which case the Provider is pursuing payment from a third party or if an Enrollee is enrolled in the Plan with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in the Plan with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the MCO receives notification from TENNCARE of the Enrollee’s eligibility/enrollment.

34. MCO shall make payment to the Provider upon receipt of a clean claim properly submitted by the Provider within the required time frames as specified in Tenn. Code Ann. §56-32-126 and Section A.2.22.4 of the Agreement.

35. The Provider shall accept payment or appropriate denial made by the MCO (or, if applicable, payment by the MCO that is supplementary to the Enrollee’s third party payor) plus the amount of any applicable TENNCARE cost sharing responsibilities, as payment in full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Enrollee in excess of the amount of applicable TENNCARE cost sharing responsibilities. Enrollee shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Enrollee being served.

36. In the event that TENNCARE deems the MCO unable to timely process and reimburse claims and requires the MCO to submit Provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the Provider shall agree to accept reimbursement at the MCO’s contracted reimbursement rate or the rate established by TENNCARE, whichever is greater.

37. Provider’s responsibilities and prohibited activities regarding cost sharing are set forth in Section A.2.6.7 of the Agreement. The Provider shall not require any cost sharing responsibilities for Covered Services except to the extent that cost sharing responsibilities are required for those services by TENNCARE in accordance with TENNCARE rules and regulations, including but not limited to, holding Enrollees liable for debt to insolvency of MCO or non-payment by the State or MCO to Provider. MCO and all Providers and subcontractors shall not charge Enrollees for missed appointments.

38. Provider shall identify third party liability coverage, including Medicare and long-term care insurance as applicable, and except as otherwise provided in the Agreement, to seek such Third Party Liability (TPL) payment before submitting claims to the MCO.

39. If Provider is compensated via a capitation arrangement, and should Provider become aware for any reason that he/she is not entitled to a capitation payment for a particular Enrollee (a patient dies, for example), Provider shall immediately notify both the MCO and TENNCARE by certified mail, return
receipt requested and the Provider shall submit utilization or encounter data as specified by MCO so as to ensure MCO’s ability to submit encounter data to TENNCARE that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

40. Provider and Subcontractors acknowledge that as a condition of receiving any amount of TENNCARE payment, the Provider and Subcontractors must comply with the applicable Fraud and Abuse section A.2.20 of the Agreement (also see Section I. Introduction of this Manual for more detailed Fraud and Abuse information).

41. Provider and Subcontractor must comply with the Affordable Care Act and TennCare policy and procedures regarding recovery of overpayments, including written notification to MCO and TennCare Office of Program Integrity (OPI) of overpayments identified by Provider and Subcontractor, and when applicable, returns overpayments to the MCO within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

42. Provider and Subcontractor, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting Provider entities that bill and/or receive TennCare funds as the result of the Agreement shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and TennCare policies and procedures including at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, within thirty-five (35) days after any change of ownership of the disclosing entity, at least once every three (3) years, and at any time upon request. For Providers, this requirement may be satisfied through TennCare’s Provider registration process.

43. Any reassignment of payment must be made in accordance with 42 CFR §447.10. All tax-reporting Provider and Subcontractor entities shall not be permitted to assign TennCare funds/payments to billing agents or alternative payees without executing a billing agent or alternative payee assignment agreement. The billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE), DMF and SAM screening by the assignee if the alternative payee assignment is on-going. Further, direct and indirect payments to out of country individuals and/or entities are prohibited.

44. Providers and/or Subcontractors shall screen their employees and Contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any federal healthcare programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider and/or Subcontractor shall be required to immediately report to MCO any exclusion information discovered. The Provider and/or Subcontractor shall be informed by MCO that civil monetary penalties may be imposed against Providers and Subcontractors who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare Members.

45. The Provider, Subcontractor or any other entity agrees to abide by the Medicaid laws, regulations, and program instructions that apply to the Provider. The Provider, Subcontractor or any other entity understands that payment of a claim by TENNCARE or a TENNCARE Managed Care Organization is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the federal anti-kickback statute and the Stark law) and is conditioned on the Provider’s, Subcontractor’s or any other entity’s compliance with all applicable conditions of participation in Medicaid. The Provider, Subcontractor, or any other entity understands and agrees that each claim the Provider, Subcontractor, or any other entity submits to TENNCARE or a TENNCARE Managed Care Organization constitutes a certification that the Provider, Subcontractor, or any other entity has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the federal anti-kickback statute and the Stark law) in connection with such claims and the services provided therein.
46. Provider shall conduct criminal background checks in accordance with state law and TennCare policy and ensure that all employees, agents, subcontractors, Providers or anyone acting for or on behalf of the MCO conducts criminal background checks and registry checks in accordance with state law and TennCare policy. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, National and Tennessee Sexual Offender Registry, MDF and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Criminal background checks and registry checks must be performed on any employee or volunteer who will have direct contact with a Member in CHOICES or ECF CHOICES. All criminal background and registry checks required in Section 2.29.2.2 of the Agreement must be completed prior to any such person having direct contact with a CHOICES or ECF CHOICES Member. Any employee or volunteer supporting CHOICES or ECF CHOICES Members, who will not have direct contact with these Members, must have required registry checks completed prior to beginning this support. Unless federal or state laws prohibit individuals with certain criminal records from holding particular positions or engaging in certain occupations, an individual whose background check reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance, including, but not limited to Section A.2.9.7.6 of the Agreement and TennCare Rules 1200-13-01.05.


48. For CHOICES and ECF CHOICES Members, the Provider shall facilitate notification of the Member’s care/supports coordinator by notifying the MCO, in accordance with the MCO’s processes, as expeditiously as warranted by the Member’s circumstances, of any known significant changes in the Member’s condition or care, hospitalizations, or recommendations for additional services.

49. Hospitals, including psychiatric hospitals, shall cooperate with the MCO in developing and implementing protocols as part of the MCO’s nursing facility diversion plan (see Section A.2.9.5.7 of the Agreement), which shall include, at a minimum, the hospital’s obligation to promptly notify the MCO upon admission of an eligible Member regardless of payor source for the hospitalization; how the hospital will identify Members who may need home health, private duty nursing, nursing facility, or CHOICES or ECF CHOICES HCBS upon discharge, and how the hospital will engage the MCO in the discharge planning process to ensure that Members receive the most appropriate and cost-effective Medically Necessary services upon discharge.

50. As applicable, as a condition of reimbursement for global procedure codes for obstetric care, the Provider shall submit utilization or encounter data as specified by the MCO in a timely manner to support the individual services provided.

51. Except as otherwise specified in Sections A.2.12.10 or A.2.12.11 of the Agreement, the Provider shall secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the MCO’s Members and the MCO under the Provider Agreement. The Provider shall maintain such insurance coverage at all times during the Provider Agreement and upon execution of the Provider Agreement furnish the MCO with written verification of the existence of such coverage; (Governmental Providers must meet this requirement in accordance with specific statutes that apply).

52. The MCO and the Provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the MCO and the Provider. The Provider Agreement hereby incorporates by reference all applicable federal law and regulations and state laws, TENNCARE rules and regulations, consent decrees or court orders, and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the Provider Agreement as they become effective. This compliance includes, but is not limited to, Sections A.2.19, A.2.21.7, A.2.25.5, A.2.25.6, A.2.25.8, A.2.25.11, E.13, E.28, E.36, and D.7 of the Agreement.
53. The Provider Agreement shall specify procedures and criteria for any alterations, variations, modifications, waivers, extension of the Provider Agreement termination date, or early termination of the Provider Agreement and specify the terms of such change. If provision does not require amendments be valid only when reduced to writing, duly signed and attached to the original of the Provider Agreement, then the terms shall include provisions allowing at least thirty (30) calendar days to give notice of rejection and requiring that receipt of notification of amendments be documented (e.g., certified mail, facsimile, hand-delivered receipt, etc.).

54. Provider acknowledges that MCO shall be allowed to suspend, deny, refuse to renew or terminate any Provider Agreement in accordance with the terms of the Agreement with TennCare (Section E.14 of the Agreement) and applicable law and regulation.

55. TENNCARE reserves the right to direct the MCO to terminate or modify the Provider Agreement when TENNCARE determines it to be in the best interest of the State.

56. MCO and Provider recognize that in the event of termination of the Agreement between MCO and TENNCARE for any of the reasons described in Section E.14 of the Agreement, the Provider shall immediately make available, to TENNCARE, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the Provider’s activities undertaken pursuant to the MCO/Provider Agreement. The provision of such records shall be at no expense to TENNCARE.

57. MCO and Provider recognize that TENNCARE Provider Independent Review of Disputed Claims process shall be available to Providers to resolve claims denied in whole or in part by the MCO as provided at Tenn. Code Ann. §56-32-126(b).

58. Provider warrants that no part of the total Provider Agreement amount provided under the Provider Agreement shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliated organization to any state or federal officer or employee of the State of Tennessee or any immediate family member of a state or federal officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to the Provider in connection with any work contemplated or performed relative to the Provider Agreement unless otherwise disclosed to the Commissioner, Tennessee Department of Finance and Administration. For purposes of this section, “immediate family member” shall mean a spouse or minor child(ren) living in the household. Provider shall ensure that it maintains adequate internal controls to detect and prevent any conflicts of interest from occurring at all levels of the organization.

59. Provider certifies that no member of or a delegate of Congress, nor any elected or appointed official or employee of the State of Tennessee, the United States General Accounting Office, United States Department of Health and Human Services, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining the Provider Agreement. The Provider Agreement may be terminated if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from Provider or Provider’s agents or employees.

60. Provider certifies that to the best of its knowledge and belief, federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. Provider shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

61. Provider shall indemnify and hold harmless the State of Tennessee as well as its officers, agents, and employees (hereinafter the “Indemnified Parties”) from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of Provider to comply with the terms of the Provider Agreement. Provider shall be provided with written notice of each such claim or suit and full right or opportunity to conduct Provider’s own defense thereof, together with full information and reasonable cooperation; but the State does not hereby accord to Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by Tenn. Code Ann. §8-6-106.
62. Provider shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits, which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from the Provider’s or Indemnified Parties’ performance under the Provider Agreement. In any such action, brought against the Indemnified Parties, Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. Provider shall be given written notice of each such claim or suit and full right and opportunity to conduct the Provider’s own defense thereof, together with full information and reasonable cooperation; but the State does not hereby accord to Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by Tenn. Code Ann. §8-6-106. While the State will not provide a contractual indemnification to the Provider, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to the Provider. The Provider retains all of its rights to seek legal remedies against the State for losses the Provider may incur in connection with the furnishing of services under the Agreement or for the failure of the State to meet its obligations under the Agreement.

63. The Provider and/or Subcontractors shall safeguard all information about Enrollees according to applicable state and federal laws and regulations as described in Sections A.2.27 and E.6 or 5.33, as applicable, of the Agreement. If the Provider and/or Subcontractors have access to Protected Health Information, the Provider and/or Subcontractors must agree to be bound by the same restrictions, terms and conditions that apply to BlueCare Tennessee pursuant to Sections A.2.27 and 5.33 of the Agreement.

64. Provider must comply with 42 CFR Part 438, Managed Care, including but not limited to 438.6(f)(2)(i), compliance with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment. At a minimum, this shall mean non-payment of Provider-preventable conditions as well as appropriate reporting as required by the MCO and TENNCARE.

65. Provider agrees to comply with BlueCare Tennessee’s quality assurance and quality improvement standards and procedures that are contained in this Manual as modified and updated from time to time in order to improve patient safety and quality.

66. MCO will provide general and targeted education to Provider regarding emergency Member appeals described in TENNCARE rules and regulations, including when an emergency appeal is appropriate, and procedures for providing written certification thereof. Provider will comply with the Member appeal process including providing certification of emergency appeals as appropriate. Provider shall provide Member appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review. In advance, Providers shall seek prior authorization, when he/she feels he/she cannot order a drug on the TENNCARE PDL and will take the initiative to seek prior authorization or change or cancel the prescription when contacted by an Enrollee or pharmacy regarding denial of a pharmacy service due to system edits (i.e. therapeutic duplication, etc.).

67. Provider agrees to coordinate with the TENNCARE Pharmacy Benefits Manager (PBM) regarding authorization and payment for pharmacy services.

68. Providers who participate in the federal 340B program shall give MCO the benefit of 340B pricing.

69. MCO may take action or sanctions against a Provider or Subcontractor as set forth in the Agreement, Section E.29 for specific failures to comply with contractual and/or credentialing requirements. This shall include, but may not be limited to a Provider’s or Subcontractor’s failure or refusal to respond to a request for information, the request to provide medical records, credentialing information, etc. At MCO’s discretion or a directive by TENNCARE, MCO shall impose financial consequences against the Provider or Subcontractor as appropriate. Liquidated damages shall not be passed to a Provider or Subcontractor unless the damage was caused due to an action or inaction of the Provider or Subcontractor. Disputes regarding whether the Provider or Subcontractor caused the damage by an action or inaction shall be handled through the Provider Dispute Resolution Procedure.
70. Provider acknowledges that TENNCARE children under 21 are eligible for the package of TennCare Kids Benefits (EPSDT) which require Provider to make treatment decisions based upon children's individual medical and behavioral health needs. TennCare Kids requirements are set forth in the Agreement at Section A.2.7.6.

71. Providers are not permitted to encourage or suggest, in any way, that TENNCARE children be placed into state custody in order to receive medical services, behavioral services, or long-term services and supports covered by TENNCARE.

72. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees.

73. Provider and Subcontractor agree that no person on the grounds of handicap, and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, except as specified in Section A.2.3.5 of the Agreement, or be denied benefits of, or be otherwise subjected to discrimination in the performance of Provider’s or Subcontractor’s obligation under its agreement with the MCO or in the employment practices of the Provider or Subcontractor. The Provider or Subcontractor shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and Enrollees.

74. Providers and Subcontractors shall have written procedures for the provision of language and communication assistance services to Members and/or the Member’s representative. Language and communication assistance services include interpretation and translation services and effective communication assistance in alternative formats for any Member and/or the Member’s representative who needs such services, including but not limited to, LEP and individuals with disabilities. Provider or Subcontractor shall provide information to Members regarding treatment options and alternative in a manner appropriate to the Member’s condition and ability to understand.

75. Provider and Subcontractor agree to cooperate with TENNCARE and the MCO during discrimination complaint investigations and to report discrimination complaints and allegations to MCO including allegations of discrimination set forth in Sections A.2.12.21.1 and A.2.15.7.6.3.2.7 of the Agreement.

76. Provider and Subcontractor shall assist TENNCARE Enrollees in obtaining discrimination complaint forms and contact information for the MCO’s Nondiscrimination Office.

77. As required by 42 C.F.R. 438.206, MCO and its Providers and Subcontractors that are providing services pursuant to the Agreement shall participate in the State’s efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including LEP, disabilities and diverse cultural and ethnic backgrounds regardless of an Enrollee’s gender, sexual orientation, or gender identity. This includes MCO emphasizing the importance of network Providers to have the capabilities to ensure physical access, accommodations, and accessible equipment for the furnishing of services to Enrollees with physical or mental disabilities.

78. If a discrimination complaint against Provider, Subcontractor or any of Provider or Subcontractor’s Providers, employees or subcontractors considered to be recipients of federal financial assistance under the terms of the Agreement is determined by the Division of TennCare to be valid, the Division of TennCare shall, at its option and pursuant to Section A.2.25.10 of the Agreement, either (i) provide MCO with a corrective action plan for the Provider or Subcontractor to resolve the complaint, or (ii) request that MCO submit a proposed corrective action plan from the Provider or Subcontractor to the Division of TennCare for review and approval that specifies what actions Provider or Subcontractor propose to take to resolve the discrimination complaint. Upon provision of the corrective action plan to Provider or Subcontractor, or approval of Provider or Subcontractor’s proposed corrective action plan by the Division of TennCare, Provider or Subcontractor shall implement the approved corrective action plan to resolve the discrimination
complaint. The Division of TennCare in its sole discretion shall determine when a satisfactory
discrimination complaint resolution has been reached and shall notify MCO of the proposed
resolution. MCO shall notify Provider or Subcontractor when the Division of TennCare determines
that a satisfactory discrimination complaint resolution has been reached. A discrimination
complaint resolution corrective action plan may consist of approved nondiscrimination training on
relevant discrimination topics. Prior to use, the nondiscrimination training material shall be
reviewed and approved by the Division of TennCare and MCO. Time periods for the
implementation of the corrective action plan nondiscrimination training shall be designated by the
Division of TennCare.

79. To the extent that Provider or Subcontractor is using electronic and information technology to fulfill
its obligations under its Provider Agreement with MCO, the Provider or Subcontractor agrees to
comply with the electronic and information technology accessibility requirements under the federal
civil rights law including Section 504 and Section 508 of the Rehabilitation Act of 1973 (“Section
508”) and the Americans with Disabilities Act (or any subsequent standard adopted by an
oversight administrative body, including the Federal Accessibility Board). To comply with the
accessibility requirements for Web content and non-Web electronic documents and software, the
Provider or Subcontractor shall use W3C’s Web Content Accessibility Guidelines (“WCAG”) level
AA or higher (For the W3C’s guidelines see https://www.w3.org/WAI/standards-
guidelines/wcag/new-in-21/). (More resources can be found at https://www.w3.org/WAI/ and

80. Neither MCO, Provider nor Subcontractor shall discriminate with respect to participation,
reimbursement, or indemnification of a Provider who is acting within the scope of the Provider’s
license or certification under applicable state law, solely on the basis of such license or
certification. Neither MCO, Provider nor Subcontractor shall discriminate against a Provider for
serving high-risk Members or if a Provider specializes in conditions requiring costly treatments.
This provision shall not be construed as prohibiting MCO, Provider or Subcontractor from limiting a
Provider’s participation to the extent necessary to meet the needs of Members. This provision
also is not intended and shall not interfere with measures established by MCO that are designed
to maintain quality of care practice standards and control costs.

81. Providers and Subcontractors agree to comply with Section 1557 of the Affordable Care Act which
prohibits discrimination on the basis of race, color, national origin, sex, age or disability.

82. Provider shall not use TENNCARE’s name or trademark for any materials intended for
dissemination to their patients unless said material has been submitted to TENNCARE by the
MCO for review and has been approved by TENNCARE in accordance with Section A.2.17 of the
Agreement. This prohibition shall not include references to whether or not the Provider accepts
TennCare.

83. If any requirement in the Provider Agreement is determined by TENNCARE to conflict with the
Agreement between TENNCARE and the MCO, such requirement shall be null and void and all
other provisions shall remain in full force and effect.

84. For Provider Agreements that include Ethical and Religious Directives provisions, the following
requirements apply:
A. The Provider shall provide a list of the services it does not deliver due to the Ethical and
Religious Directives to MCO. MCO shall furnish this list to TennCare, noting those
services that are TennCare Covered Services. This list shall be used by MCO and
TennCare to provide information to Members about where and how the Member can
obtain the services that are not being delivered by the Provider due to Ethical and
Religious Directives.
B. At the time of service, the Provider shall inform Members of the health care options that
are available to the Members, but are not being provided by the Provider due to the
Ethical and Religious Directives, but the Provider is not required to make specific
recommendations or referrals. In addition, the Provider shall inform Members that the
Member’s MCO has additional information on providers and procedures that are covered by TennCare.

85. As applicable, if the Provider Agreement is with a local health department, it shall meet the minimum requirements specified in Sections A.2.12.8 and A.2.12.9 of the Agreement and shall also specify for the purpose of TennCare Kids screening services: (1) that the local health department agrees to submit encounter data timely to the MCO; (2) that the MCO agrees to timely process claims for services in accordance with Section A.2.22.4 of the Agreement; (3) that the local health department may terminate the Provider Agreement for cause with thirty (30) days’ advance notice; and (4) MCO agrees prior authorization shall not be required for the provision of TennCare Kids screening services.

86. Provider must disclose to MCO whether his/her license is under federal DEA restriction that pertains to prescribing and/or dispensing certification for scheduled drugs.

87. Provider may not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the Provider’s contractual obligation with the MCO.

88. MCO, Provider and/or Subcontractor shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in the Agreement and any other costs and expenditures made under the Agreement. Specific accounting records and procedures are subject to TENNCARE and federal approval. Accounting procedures, policies, and records shall be completely open to state and federal personnel at any time during the Provider Agreement period and for five (5) years thereafter unless otherwise specified elsewhere in the Provider Agreement.

89. Provider and/or Subcontractors must have a Tennessee Medicaid Provider number, issued by TENNCARE, in order to receive payment from the MCO. Provider/Subcontractor must also have a National Provider Identifier (NPI) number, issued by CMS where applicable.

90. No Payment Outside of the U.S. – Provider and/or Subcontractor agrees that all Covered Services to be performed herein shall be performed in the United States of America, and Provider and/or Subcontractor agrees that Provider and/or Subcontractor shall not provide any payments for items or services provided under the Agreement to any financial institution, entity or person located outside the United States of America. Furthermore, Provider and/or Subcontractor is prohibited to transfer Member data in any form via any medium to any third party beyond the boundaries and jurisdiction of the United States without the prior written consent of MCO. For purposes of implementing this provision, Section 1101(a)(2) of the Social Security Act (the “Act”) defines the term “United States” when used in a geographical sense, to mean the “States.” Section 1101(a)(1) of the Act defines the term “State” to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

91. MCO shall require all its Subcontractors to adhere to HIPAA standard transaction requirements.

92. Prior to the use of any Subcontractor in the performance of this Agreement, and semi-annually thereafter, during the period of this Agreement, the MCO shall obtain and retain a current, written attestation that the Subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Agreement and shall not knowingly utilize the services of any Subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Agreement. Attestations obtained from such Subcontractors shall be maintained by the MCO and made available to State officials upon request.

93. If a Subcontract is for the provision or management of behavioral health services, the Subcontractor shall comply with the requirements in Section A.2.6.1.2 of the Agreement regarding integration of physical health and behavioral health services.
94. If the Subcontractor will conduct level of care or needs assessments or reassessments and/or develop or authorize plans of care, the Subcontractor shall not provide any direct long-term services and supports.

95. If the Subcontractor shall perform utilization management activities, Subcontractor agrees that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to any Member, as provided by the Balanced Budget Act of 1997 and the provisions of 42 CFR §438.210(e).

96. As required in Section A.2.30.20 of the Agreement, where the MCO has subcontracted claims processing for TennCare claims, the MCO shall provide to TENNCARE a Type II examination based on the Statement on Auditing Standards (SAS) No. 70, Service Organizations for each non-affiliated organization processing claims that represent more than twenty percent (20%) of TennCare medical expenses of the MCO. This report shall be performed by an independent auditor ("service auditor") and shall be due annually on May 1 for the preceding year operation or portion thereof. The service auditor shall conduct the Type II examination and express an opinion in the manner set forth in Section A.2.30.20 of the Agreement.

97. Subcontractor shall not conduct any Enrollee marketing activities in accordance with Section A.2.16 of the Agreement. Any Subcontractor general marketing or distribution of Member materials shall be performed in accordance with Sections A.2.16 and A.2.17 of the Agreement and require prior written approval by TENNCARE and TDCI.

98. Subcontractor shall collect disclosure of healthcare related criminal conviction information as required by 42 CFR §455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. Subcontractors shall agree to disclose business transaction information upon request and as otherwise specified in federal and state regulations.

99. Transportation and claims processing Subcontractors shall be assignable from BlueCare Tennessee to the State, or its designee: i) at the State's discretion upon written notice to BlueCare Tennessee and the affected Subcontractor; or ii) upon BlueCare Tennessee's request and written approval by the State. Further, Subcontractor agrees to be bound by any such assignment and that the State, or its designee, shall not be responsible for past obligations of BlueCare Tennessee.

100. Effective with any new Subcontracts or upon the next amendment to existing Subcontracts, Subcontractor acknowledges that the Subcontract may be terminated by BlueCare Tennessee for convenience and without cause upon thirty (30) calendar days written notice.

101. Subcontractor shall make available, for the purposes of an audit, evaluation or inspection by the State, CMS, the DHHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its TennCare Members. All inspections and evaluations shall be performed in such a manner as to minimize disruption of normal business.

102. In accordance with the terms of the Agreement, and applicable to our BlueCare and TennCareSelect networks only, BlueCare Tennessee shall not reimburse Provider any TennCare rates based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.

103. Provider shall require that all staff employed by Provider and delivering employment services to ECF CHOICES Members obtain certification and training pursuant to TennCare guidance and as required for compliance in the ECF CHOICES program.

No other terms or conditions agreed to by BlueCare Tennessee and the Provider shall negate or supersede the requirements listed in Section A.2.12.9 of the Agreement.
104. The following requirements are applicable to Provider Agreements between MCO and home health agency Providers (“HHA”):

A. HHA shall comply with the federal regulations delineating the conditions of participation that HHAs must meet in order to participate in the Medicaid program.

B. HHA must supply each Enrollee with the following:
   
   i. Written and verbal notice of the Enrollee’s rights and responsibilities as a home health patient as required under 42 CFR §484.50(a);
   
   ii. Written and verbal notice of the HHA’s policy for transfer and discharge as required under 42 CFR §484.50(d), including an explanation in plain language that disruptive, abusive, or uncooperative behaviors could give rise to a “discharge for cause,” and the requirements that must be satisfied by the HHA in order for transfer or a discharge to be effectuated; and
   
   iii. Written and verbal notice of the HHA’s obligation to accept complaints made by the Enrollee about the care that is (or fails to be) furnished, and of the HHA’s obligation to investigate, document, and resolve these Enrollee complaints (as well as complaints of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, or injuries of unknown source, or misappropriation of the Enrollee’s property by anyone furnishing care on behalf of the HHA) as required under 42 CFR §484.50(e).

C. The HHA must explain to the Enrollee the scope of the home health services that the Enrollee will be receiving. Afterwards, the HHA must obtain the signature of the Enrollee verifying that an HHA staff member has explained the scope of services to the Enrollee. Likewise, the HHA must obtain, as required under 42 C.F.R. §484.50(a)(2), the Enrollee’s or the legal representative’s signature confirming that they received written notice of the Enrollee’s rights and responsibilities as required by Section A.2.12.23.1.1 of the Agreement. The HHA must maintain all signature(s) in their record of the Enrollee.

D. The HHA must develop a back-up plan for each Enrollee to be implemented during missed visits, as defined by Section A.2.15.9.1 of the Agreement, or when otherwise necessary.

E. When the HHA is notified before a missed visit occurs or as it is occurring, the HHA must contact the Enrollee and implement the back-up plan or offer a suitable alternative service. The HHA must report all missed visits to the MCO in writing within three calendar days of the missed visit. This report must be submitted on an MCO-approved form, which captures all of the information the MCO requires, including, but not limited to, the following: the identity of the Enrollee; the type of service involved; the date of the missed visit; the cause(s); and, what corrective action was taken to mitigate the cause(s) of the missed visit. The HHA must ensure that the staff member enters notes about the circumstances of a missed visit in every instance in which notes are possible.

F. When a conflict arises between an Enrollee and an assigned HHA staff member, or when an Enrollee refuses to allow an assigned staff member to begin or to complete their assigned visit, the staff member will immediately notify the HHA. Once notified, the HHA will contact the Enrollee and offer to either (1) implement the existing back-up plan or (2) staff the care with a qualified alternative staff member. In every instance, the HHA must record these missed visits, as described above, and timely submit them to the MCO. All of the aforementioned facts should be included in the reports with as much written explanation as possible regarding the causes and factors contributing to the conflict. If additional conflicts arise between the Enrollee and the HHA or alternative staff member (for example, if an Enrollee refuses to admit the alternative staff member into Enrollee’s home), the HHA must notify the MCO and must continue making reasonable efforts to staff the approved care with qualified alternative staff members until the HHA, in its discretion, plans to discharge the Enrollee for cause. At that point, the HHA must notify the MCO of its decision to discharge or transfer the Enrollee.
DEFINITIONS

Periodically, definitions found in the Provider Agreements may need to be revised or new definitions will need to be added in order to remain consistent with the Agreement. The following definitions have been revised or included as set forth below. All other capitalized terms in this section XII shall have the meaning as set forth under the Agreement.

Benefit Appeal – As distinguished from an Eligibility Appeal, a “Benefit Appeal” concerns an Enrollee’s request to contest an MCO’s Adverse Benefit Determination by requesting a State Fair Hearing (“SFH”). CMS has determined that the provisions contained in 42 C.F.R. 438 subpart F, which require MCOs to maintain an internal appeal system, and which requires Enrollees to exhaust the MCO internal appeal process before being permitted to request a SFH, are satisfied by TennCare’s requirement that MCO comply with the “Reconsideration” phase of the SFH process (also called the “appeal process”). In accordance with CMS approval, BlueCare Tennessee shall not have an internal appeal process that Enrollees are required to exhaust before they may request a SFH through the TennCare appeal process. BlueCare Tennessee’s “Reconsideration” of its initial Adverse Benefit Determination during the TennCare appeal process is deemed by CMS to satisfy the requirement for a MCO-level appeal.

Covered Services or Benefits – The package of health care services, including physical health services, behavioral health services, and long-term services and supports, that define the Covered Services available to TennCare Enrollees assigned to BlueCare Tennessee.

Enrollee – A person who has been determined eligible for TennCare and who has been enrolled in the TennCare program (see Member, also). Synonymous with Member. For purposes of Enrollee Benefit Appeals and the Enrollee Benefit Appeal-related provisions in Section A.2.19 of the Agreement, “Enrollee” means (1) Enrollee, (2) Enrollee’s parent, (3) Enrollee’s legal guardian or (4) the Enrollee-Authorized Representative as defined in the Agreement. For purposes of Provider Agreements in Section 2.12.23 of the Agreement, and missed visits of home health services in Section A.2.15.9 of the Agreement, “Enrollee” means not only (1) the enrollee, (2) the enrollee’s parent, or (3) the enrollee’s legal guardian, but also a person who has a close personal relationship with the enrollee and is routinely involved in providing unpaid support and assistance to them.

Enrollee Authorized Representative - For purposes of Enrollee Benefit Appeals, and the Enrollee-Benefit Appeal-related provisions in Section A.2.19 of the Agreement, “Enrollee Authorized Representative” means a competent adult who has the Enrollee’s signed, written authorization to act on the Enrollee’s behalf during the Appeal Process in accordance with 42 C.F.R. §435.923. The written authority to act shall specify any limits of the representation. For example, if the Enrollee wants to authorize his treating Provider to frame the issue under dispute and file his request for a SFH, but if his treating Provider will not be receiving the Notice of Hearing and will not be representing the Enrollee during the hearing, these limitations shall be indicated on the Enrollee-Authorized Representative documentation.

Grievance – A complaint or an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee’s rights regardless of whether remedial action is requested. Grievance includes an Enrollee’s right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision. See 42 CFR §438.400(b).

Reconsideration – Mandatory component of the TennCare Benefit Appeal Process by which an MCO reviews and renders a decision affirming or reversing the Adverse Benefit Determination at issue in the Enrollee’s request for SFH. An MCO satisfies the plan-level requirements of 42 C.F.R. §438 Subpart F when the review includes all available, relevant, clinical documentation (including documentation which may not have been considered in the original review); is performed by a Physician other than the original reviewing physician; and produces a timely written finding.
State Fair Hearing (“SFH”) – The Benefit Appeal Process set forth in subpart E of part 431 chapter IV, title 42 under which TennCare Enrollees have the right to request a SFH (synonymous with “Appeal”) to contest the MCO-proposed Adverse Benefit Determinations. CoverKids/CHIP program Enrollees do not have the right to receive a SFH, but may receive a CoverKids “Review”. See 42 CFR §438.400(b).
XIII. Abortion, Sterilization, Hysterectomy (ASH)

(This section applies to CoverKids effective 6/1/16)

A. Abortion

BlueCare Tennessee covers abortions pursuant to applicable federal and state laws and regulations. Abortions and services associated with the abortion procedure are covered when the abortion is Medically Necessary as the mother suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself that would place the mother in danger of death unless an abortion is performed or the pregnancy is the result of an act of incest or rape. Abortions are a Covered Service only when all of the guidelines listed below are met:

- A Certification of Medical Necessity for Abortion form must be correctly completed with the following:
  * Date of Service: The date the abortion was performed;
  * Member full name;
  * Member Date of Birth;
  * Member Complete Address;
  * Condition;
  * Supporting Documentation;
  * Physician Name, NPI, and Address; and
  * Physician Signature/Date

  **Note:** This form may be typed or handwritten; however, the Physician's signature must be in his/her own handwriting - a stamped signature is not acceptable. All fields on consent form must be legible.

- Documentation required: History and physical, operative report, pathology report, ultrasound report of fetal demise (if applicable).

- Elective abortions are not covered under BlueCare or TennCare Select. The following are examples of conditions, which may allow BlueCare Tennessee to cover the cost of an abortion if the Member's life is endangered:

  - Pregnancies complicated by:
    * Injuries sustained in a motor vehicle accident;
    * Severe maternal cardiac disease.
    * Thromboembolic disease;
    * Severe hypertension;
    * Genital, urinary tract, or pelvic infection;
    * Delayed or excessive hemorrhage;
    * Renal failure;
    * Damage to pelvic organs or tissues;
    * Metabolic disorder;
    * Shock (includes septic and endotoxic);
    * Embolism; and/or
    * Maternal coma.

  **Note:** Medical records documenting the life saving nature of the abortion must be submitted with the claim.

- Abortion in the case of a pregnancy resulting from an act of rape or incest is covered if there is:
  * documentation from a law enforcement agency indicating the Member has made a credible report as the victim of incest or rape;
  * documentation from a public health agency, Department of Human Services, or Counseling Agency (such as Rape Crisis Center) indicating the Member has made a credible report as the victim of incest or rape; or
  * documentation by the treating Practitioner that the Member was unable, for physical or psychological reasons, to comply with the reporting requirement

- Ectopic and molar (hydatidiform) pregnancies
Previously failed attempted abortion
- Rectal cancer and/or invasive cancer of the cervix warrant immediate removal of the malignancy and often require hysterectomy or whole pelvis radiation and, if diagnosed early in pregnancy, may require abortion of fetus.

Conditions, such as congenital abnormalities/anomalies, chromosomal abnormalities, advanced maternal age, polygenic/multifactorial disorders (e.g., spina bifida or anencephaly), maternal substance abuse, HIV-positive diagnosis or exposure, or viral infections generally do not endanger a Member's life to the degree that an abortion would be necessary.

The Certification of Medical Necessity for Abortion form in both English and Spanish may be accessed and printed online at https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html.

Instructions for Completing the Certification of Medical Necessity for Abortion Form
Except where noted, response may be typed or handwritten.

1. Date of Service: The date the abortion was performed;
2. Patient's Full Name;
3. Patient's Date of Birth;
4. Patient Address: The Member’s complete address including street, city, state, and zip code;
5. Condition: Mark the block indicating the applicable reason for the abortion;
6. Supporting Documentation: Mark the block that applies to the type of supporting documentation.
7. Physician’s NPI# and address: The Physician’s NPI# and complete address including street, city, state and zip code; and
8. Physician’s Signature/Date: The Physician must sign his/her name in his/her own handwriting after the procedure.

Note: Incomplete information on the Certification of Medical Necessity for Abortion form will result in denial of the claim to request additional information. All fields on consent form must be legible.

B. Sterilization

BlueCare Tennessee covers sterilization pursuant to applicable federal and state laws and regulations. Sterilization is a Covered Service only when all of the guidelines listed below are met:

1. The individual to be sterilized is at least 21 years old at the time consent is obtained.
2. The individual to be sterilized is mentally competent.
3. The individual to be sterilized is not institutionalized, not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility, or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.
4. There must be 30 days between the date of Member’s signature and the date of sterilization procedure. In the case of premature delivery, there must be at least 72 hours between the day and time the Member signed the consent form and the day and time the sterilization is performed. At least thirty (30) days would have had to lapse between the date the Member signed the consent form and the individual’s expected date of delivery. In the case of emergency abdominal surgery, there must be at least 72 hours between the day and time the Member signed the consent form and the day and time the sterilization is performed. The consent form expires 180 days from the date of Member’s signature.
5. The sterilization consent form must be completed and attached to the claim.
6. Physician must sign line 23 on the consent form AFTER surgery.
7. Correctly completed consent form must be attached to the claim form when submitted for reimbursement.
8. Operative report should be attached to claim.

Federal law requires a valid and current consent form for sterilization procedures. Make sure your office is using the most up-to-date sterilization consent form. Claims filed with out-of-date forms will be denied.

C. Hysterectomy

BlueCare Tennessee covers hysterectomies pursuant to federal and state laws and regulations. Hysterectomy is a Covered Service when all the guidelines below are met:

1. The hysterectomy is Medically Necessary.
2. The Member or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

Hysterectomies Will Not Be Covered If:

- Performed solely for the purpose of rendering an individual permanently incapable of reproducing;
- There is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing; or
- It is performed for the purpose of cancer prophylaxis.

Requirements For Filing A Hysterectomy Claim

- The Title XIX Acknowledgement of Hysterectomy Information form must be correctly completed and attached to the claim form.
- Physician must sign the Title XIX Acknowledgement of Hysterectomy Information form AFTER procedure is performed when completing Section C.
- Documentation required: a detailed history and physical and/or office notes to include conservative measures tried prior to procedure, operative report, pathology report, correctly completed consent form.

The Acknowledgement of Hysterectomy Information form and instructions for completing the form may be accessed and printed online at https://www.tn.gov/tenncare/providers/miscellaneous-provider-forms.html.

D. ADDITIONAL INFORMATION FOR FILING ABORTION, STERILIZATION, HYSTERECTOMY (ASH) CLAIMS

- All ASH claims, or claims for procedures which result from an abortion, sterilization or hysterectomy, are required by the state to have an informed consent (TDH-603 or TDHE-605) or a Physician’s Certification of Medical Necessity form filled out correctly and completely as per the instructions in this Manual.
- These forms and the medical documentation to determine Medical Necessity of the procedures must be attached to the claim for services when the claim is submitted.
- Coding errors often create problems with claims. Always verify that the code elected to bill is the code most appropriate for the procedure. Because of the large number of CPT® codes for these applicable procedures, often Physician identification and verification of the selected code is advisable.
- All claims filed with an ICD-10 and CPT® code that absolutely or possibly indicate an abortion, sterilization, or hysterectomy was performed must also include the required documentation referenced above.
- Completed certification forms (if applicable).
- Supporting medical documentation (detailed history and physical and/or office notes, operative report, pathology report, ultrasound report of fetal demise, if applicable).
Note: Specific questions regarding Sterilizations, Hysterectomies, or Abortions can be answered by calling the Regional Provider Service line. (Please refer to the Quick Reference Sheet, Section I., for specific telephone numbers.)

E. Associated Anesthesia Services

In accordance with federal guidelines (CFR 42) governing the use of federal funds, BlueCare Tennessee will perform a full prepayment review for anesthesia services for procedures related to abortions, hysterectomies, and sterilizations.

The prepayment review must be done on claims filed with an ICD-10 and CPT® anesthesia code that are absolutely or possibly indicate an abortion, sterilization, or hysterectomy. Claims submitted for these procedures will only be paid upon receipt of all required documentation. Documentation required for prepayment review of the claims includes:

- Completed certification forms, and
- Supporting medical documentation (Detailed history and physical and/or office notes, operative report, pathology report, ultrasound report of fetal demise, if applicable).

Note: Prior authorizations for the above services do not take the place of required documentation. Until full documentation for the above types of claims is received by BlueCare Tennessee, claims received for associated services of the above will be denied. However, the denied claims do not need to be resubmitted to BlueCare Tennessee in order to be paid; BlueCare Tennessee will reopen the claims and consider them for payment upon receipt of the required documentation. Prior to filing claims with BlueCare Tennessee, Practitioners may want to check with the treating surgeon to determine if all documentation has been submitted.
XIV. Preventive Care

A. Prevention and Wellness

BlueCare Tennessee provides coverage for mammography screening for diagnostic purposes as recommended by a Member’s Practitioner in accordance with guidelines outlined in Tennessee Code Annotated 56-7-2502:

- A baseline mammogram for women thirty-five (35) to forty (40) years of age;
- A mammogram every two (2) years, or more frequently based on the recommendation of the woman’s Practitioner, for women forty (40) to fifty (50) years of age; and
- A mammogram every year for women fifty (50) years of age and over.

BlueCare Tennessee provides coverage for Chlamydia screening in accordance with guidelines outlined in Tennessee Code Annotated 56-7-2606:

- One (1) annual Chlamydia screening test in conjunction with an annual pap smear for covered females who are up to twenty-nine (29) years of age and older if the screening test is determined to be Medically Necessary.

BlueCare Tennessee maintains internal tracking systems that identify current well-care and preventive services screening status and pending screening due dates for each Member.

Telephonic, mailed, emailed and Web-based reminders promote awareness and emphasize the importance of well-care and recommended preventive screenings, tests and examinations. Preventive reminders include, but are not limited to the following:

- Adult BMI Assessment
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Assistance with Smoking and Tobacco Cessation
- Asthma Care (medication management)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening (Mammogram)
- Cervical Cancer Screening (Pap Smear)
- Childhood Immunization Status Combo 10
- Chlamydia Screening
- Comprehensive Diabetes Care (HbA1c testing and control, Eye examination, Screening for Nephropathy)
- Follow-up Care for Children Prescribed ADHD Medication
- Immunizations for Adolescents Combo 2
- Influenza and Pneumococcal Immunizations
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Well-Care Visits (Preventive exams)

The TennCare Contractor Risk Agreement (CRA) and TennCare Select Agreement (TSA) require that the Managed Care Organization (MCO) develops programs and participates in activities to enhance the general health and well-being of Members. Literature review and studies show that early detection and preventive care can help populations stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health care costs.
To this end, BlueCare Tennessee Clinical Improvement coordinates the development, implementation and monitoring of prevention and wellness campaigns. The goals of these campaigns are to:

- Promote continued health and wellness within our Member population
- Comply with the CRA/TSA
- Support the State of Tennessee’s preventive health care initiative
- Improve preventive and chronic care screening rates as determined by HEDIS®

Preventive reminders and health promotion messages are disseminated through various avenues including, but not limited to:

- Reminder calls
- Member Scoreboards – (A “traffic light” system utilized to indicate the status of each screening/test – green for complete and on track, red for outstanding/past due, and yellow to reflect tests that are done annually and are due by the end of the year)
- Postcards, brochures, newsletters, e-mail
- BlueCare Tennessee website and social media (Facebook page)
- Member, Provider and Community outreach activities
- Population Health activities

Content of educational brochures, postcards, and wellness/preventive reminder scripts is reviewed annually, and revised as needed to ensure that the verbiage is in agreement with current evidence-based information, nationally recognized guidelines, in compliance with regulatory guidelines such as EPSDT, and is consistent with other developed materials.

Telephonic, e-mail, and mailed reminder campaigns provide education and health promotion messages to Members in appropriate age bands and relevant to their health risk and condition. Telephonic preventive reminder campaigns are implemented using outbound dialer technology or Computerized Telephony Integration (CTI). A message is played upon answer by a person or an answering machine/voice mail. Members not reached telephonically are sent the message via e-mail or print. The campaign schedule is coordinated with national health observance months when applicable.

Campaign content (telephonic reminder scripts, e-mail, and printed postcards/brochures) is developed following established evidence-based guidelines for physical and behavioral health conditions and preventive maintenance. Guidelines from recognized sources are the basis for these campaigns and include best practice recommendations from organizations such as the American Diabetes Association, American Heart Association, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, and National Institutes of Health.

In addition to CTI campaigns, other prevention and health promotion outreach activities include, but not limited to:

- Member Newsletters
  - BlueCare Way
  - TennCareSelect Source
  - Just For You (for BlueCare and TennCareSelect Members under age 21 years)
- Monthly Postcard Reminders
  - Mammography/Pap Test monthly reminders – mailed to Members with Breast and Cervical Cancer Screening gaps in care
- Tdap quarterly reminders – mailed to pregnant women
Provider Outreach

- Educational brochures and tool kits are developed and distributed through face-to-face visits, mail and available on BCBST and BlueCare Tennessee websites
- Member gaps in care detail for key quality indicators is available to Providers in educational packets based on the practice and population, Availity, Quality Care Rewards Tool and during face-to-face visits conducted by Regional Medical Director; Member; Provider and Community Outreach; Population Health Management and/or a Clinical Team.

Newsletter topics are selected to educate Members about physical and behavioral health conditions and promote awareness of preventive services, the importance of well-care, and how to be proactive with health. Health promotion topics are chosen based on CRA requirements and include but are not limited to: Helping stop tobacco use, CaringStart notice/Text4Baby promotion, DentaQuest, Health Care Disparities, Appropriate prescription use, Healthy nutrition, other healthy and safe lifestyles and how to access a Primary Care Provider. Content is supported by evidence-based guidelines and current standards of care.

BlueCare Tennessee has multiple areas that are involved in prevention and wellness activities: Clinical Improvement; Care Management; Population Health Management; Provider Quality and Community; Outreach; Emergency Services Management; BlueCare Operations/Member Education; and Vendors (such as 24/7 NurseLine). Activities are coordinated and enhanced for optimum impact and to address the needs of the Member population.

Activities are monitored through process measures that include, but are not limited to, the following:

- Number of Members called
- Number of Members contacted
- Success (contact) rate
- Number of postcards mailed
- Number of newsletters mailed
- Number of appointments scheduled
- Number of screenings completed

HEDIS Effectiveness of Care and Access/Availability of Care Prevention and Chronic Care, and Utilization measures are utilized to assess member outcomes and effectiveness of activities.

B. Preventive Care Guidelines

BlueCare Tennessee is committed to assisting Practitioners in the provision of preventive care services (also see Section XX. TennCare Kids). The implementation of preventive health guidelines has the potential to reduce undesirable variation in the process and outcome of care. Therefore, BlueCare Tennessee chooses preventive health guidelines appropriate to its membership and its operation to further the program goals. Additional information on preventive care guidelines for Members under the age of 21 years can be found in this Manual in Section XX. TennCare Kids.

BlueCare Tennessee policy and procedure directs that nationally recognized guidelines be utilized when available. All clinical practice guidelines are reviewed at least annually, with more frequent review being initiated if new scientific evidence or national standards are published prior to the review date. Practitioner input and involvement in the adoption of the guidelines occurs through participation in Regional Advisory Panels (RAPs).

BlueCare Tennessee has adopted the Guide to Clinical Preventive Services, as its recommended best practice reference for clinical preventive services. This publication was developed by the U.S. Preventive Services Task Force (USPSTF) as part of an initiative of the Agency for Healthcare Research and Quality.
(AHRQ), and is endorsed by the U.S. Department of Health and Human Services, the Public Health Service, the Office of Public Health and Science, and the Office of Disease Prevention and Health Promotion.

The above listed publication and additional Preventive Services information can be viewed via the Provider page on the company website, http://bluecare.bcbst.com.

Paper copies of the guidelines are available upon request by calling 423-535-6705.

The Preventive Services Web page allows quick access to a number of adult preventive services resources including links to:
- An Adult Preventive Services Flow Sheet that can be printed and used in practice medical records; http://bluecare.bcbst.com/forms/Provider%20Forms/Adult-Preventive-Health-Flow-Sheet.pdf
- A tutorial for use in training practice office staff in Adult Preventive Services; and
- U.S. Preventive Services Task Force (USPSTF) publications.

Access to a number of tools and resources related to children’s preventive services to include a direct link to the Recommended Childhood Adolescent Immunization Schedules can be found on BlueCare Tennessee website, http://bluecare.bcbst.com/ and the TennCare website at https://www.tn.gov/tenncare/section/tenncare-kids.

**Immunization Guidelines: Pediatric/Adult**

**General Principles/Policies**

The objectives of the Preventive Care guidelines are to:

1. Define BlueCare/TennCareSelect requirements for Primary Care Providers (PCPs) in administering immunizations and providing periodic health assessment for BlueCare Tennessee Members.
2. Raise the overall immunization levels of BlueCare Tennessee Members and, over time, reduce the incidence of vaccine-preventable diseases. In addition, where appropriate, specific adult Member groups (e.g., pregnant women) are addressed.
3. Address pediatric and adult requirements to maintain the immunity provided by some childhood immunizations through periodic boosters.
4. Assist PCPs in detecting and/or preventing health problems through periodic health assessments.

Adherence to the guidelines also allows BlueCare Tennessee to monitor immunization levels and provide the PCP with feedback related to BlueCare Tennessee Member immunization programs. Preventive care responsibilities are shared by the Member and his or her PCP and BlueCare Tennessee. The following outlines specific responsibilities:

**Member Responsibilities**

- Advise PCP of previous immunizations (re-advise whenever a new PCP relationship is begun);
- Seek immunizations for self and dependent pediatric Members; and
- Assume responsibilities for personal wellness by utilizing the PCP and adhering to immunization schedules to establish and maintain immunization levels.
Primary Care Practitioner Responsibilities

- Practitioners and other health care providers who administer vaccines should maintain detailed records containing information about previous vaccinations. BlueCare Tennessee will be using medical record review and administrative data to calculate its immunization rates.

- Adolescent and childhood immunization information can be obtained from the medical record when there is evidence that an antigen was rendered from:
  - a note indicating the name of the specific antigen and the date of the immunization;
  - a certificate of immunization prepared by an authorized health care Provider or agency including the specific dates and types of immunizations administered, or
  - notes in the medical record indicating that the Member received the immunization "at delivery" or "in the hospital".

- Documentation indicating the member is up to date with all immunizations that does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization reporting according to HEDIS specifications.

- All health care Providers are encouraged to share details of any TennCare Kids or preventive care encounter provided to BlueCare or TennCareSelect Members with the Primary Care Provider (PCP) shown on the Member’s ID card. Sharing this information will help ensure the Member’s assigned PCP does not duplicate any services. Instead, only the age-appropriate services due will be provided at the Member’s next office visit. Specialists, school clinics, health departments or other PCPs providing TennCare Kids services may document this information 1) on a specific preventive care form, 2) in office notes, 3) in a memo, or 4) in a letter and either fax or mail it to the assigned PCP’s office.

- Provide the recommended immunizations for both pediatric and adult Members in accordance with recommended immunization schedules or on request of the Member or Member’s parent or guardian;

- Determine, during any primary care encounter, if a vaccine is needed to establish or maintain the recommended immunity;

- Obtain a history of immunizations rendered elsewhere. If unable to obtain such information, document the attempts made in the medical record;

- Enter immunization status in Member medical records, including any medical contraindications and refusal by Member or Member’s guardian; and

- Inform the Member, or the Member’s parent or guardian, of the risks and benefits of the immunization procedures, as per the National Vaccine Compensation Legislation (Public Law 100-203 and 101-239). This includes written documentation in the medical record and to the Member.

- Situations occur where children may have private health insurance and Medicaid as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid. The options are described below:
  - Option 1
    A Provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee.
  - Option 2
    A Provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.
BlueCare/TennCare Select Responsibilities

- Provide and/or support a monitoring system that tracks the number of pediatric and adult Members immunized at the levels recommended by national and local standards;
- Assist Providers in educating Members on the benefits of immunizations and the recommended schedule for immunizations; and
- Recommend to Providers immunizations and schedule for administering.

The Recommended Childhood Immunization Schedule, approved by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians, is published annually and is recommended for all infants and children. The schedule shows all the immunizations a child should receive beginning at birth. Also available are recommendations for the delivery of adult immunizations. For the most current schedules, please visit the Centers for Disease Control website, www.cdc.gov/vaccines/schedules/.

Medical Record Documentation

**Member’s Medical Record in PCP Office**

There should be a completed immunization record or notation that immunizations are up to date in the medical record. A notation is also to be included in the Member’s medical record that literature concerning adverse clinical symptoms was distributed to the Member. Such symptoms, e.g., convulsions that may result in significant residue or may even be life threatening, are frequently unpredictable.

Additionally, any temporarily associated adverse reactions or side effects (e.g., fever, rash, tenderness, induration) severe enough to require the Member to seek medical attention should be recorded, evaluated, and reported to local and state health officials. Specific symptoms are defined in the National Vaccine Compensation Legislation (Public Law 100-203 and 101-239).

- If medical contraindications prevent vaccination, documentation must be present in the medical record.
- Documentation must exist where at least two attempts have been made to contact BlueCare Tennessee Members for scheduled immunizations. This applies especially if a Member has missed an appointment where a vaccination should have been given.
- If the Member or the Member’s guardian refused vaccination, documentation to that effect must be recorded in the medical record.

**Immunization Schedule and Record for the Member**

Information on the recommended schedule for immunization should be provided to the Member by the PCP. An immunization record should also be provided for the Member’s use. Providers should encourage parents or guardians to maintain a copy of their child’s immunization record and bring the record to each visit. If the parent or guardian fails to bring the record, a new one should be issued.

**Standards for Periodic Health Assessment**

**Informed Consent**

Members should be informed of the benefits and risks of vaccines. Such benefits and risk information should be presented in terms as simply as possible. Members should be given ample opportunity for questions before each immunization and informed consent should be signed.

**Monitoring**

As part of BlueCare Tennessee’s Clinical Quality Improvement Program, clinical indicators related to required medical record keeping practices and immunization administration and documentation will be monitored on a continuous basis. Member charts will be reviewed and measured by these immunization standards, as well as the Medical Records Standards found in Section XVII. Credentialing in this Manual. Results of the review will be used in the Quality Improvement Program.
Guidelines for Periodic Health Assessments of Adults

Periodic Assessments for Non-pregnant Adults
BlueCare Tennessee will encourage adult Members to seek periodic health assessments according to the preventive health standards outlined by TennCare and the U.S. Preventive Services task force on the advice of their Primary Care Provider. Guidelines found at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Clinical-Practice-Guidelines.html.

Aged and Frail Elderly
BlueCare Tennessee recognizes the interaction of both physical and psychosocial well-being of its Members and especially encourages PCPs and referral consultants to be aware of any evidence of physical and/or mental abuse of the aged and frail elderly. Treatment and counseling should be given as deemed necessary.

TennCare Preventive Health Standards for Non-Pregnant Adults
Initial Visit - Ages 21 and above

History - Establishment of a database for the Member, which includes the following components:

- **Past Medical History** - Includes past problems both medical and social, history of any significant illnesses or treatments, past hospitalizations or surgeries or pregnancies, any medications, which are used on a regular basis.
- **Family History** - Chronic hypertension, blood disorders, chronic obstructive pulmonary disease, diabetes mellitus, endocrinopathy, chronic renal disease, hearing problems, neurologic/seizure disorder, autoimmune disease, cancer, psychiatric disease, addictions, special emphasis given to known inheritable disorders including, if necessary, the drawing of a family tree.
- **Present History** - Current problems or signs or symptoms of illness, date of onset, length and severity of symptoms, symptom changes over time, association of symptoms with other activities, time of day, place of occurrence, any medication use or attempts at treatment by the Member or other health care Providers, diet, physical activity, tobacco, alcohol, drugs, and sexual practices.

Review of Systems - Questions covering each system:

- Cardiovascular
- Psychosocial
- Musculoskeletal
- HEENT
- Genitourinary
- Endocrine
- Gastrointestinal
- Hepatobiliary
- Neurologic
- Pulmonary

Physical Exam

Measurement - Height, weight, BMI, pulse, blood pressure, respiratory rate and temperature, as needed.

Examination - General characteristics, skin/hair, HEENT/fundi, mouth/teeth, neck/thyroid, breast/nipples, heart, lungs, abdomen, extremities, neurologic, genitalia, pelvic exam, and rectal exam, as indicated.

Laboratory - As indicated for the evaluation of expressed problems or findings in the present, past or family history or on the physical examination or as indicated in the periodicity section below.

BlueCare Tennessee provides coverage for mammography screening for diagnostic purposes as recommended by a patient’s Practitioner according to the following guidelines, in compliance with Tennessee Code Annotated 56-7-2502 which includes:

- A baseline mammogram for women thirty-five (35) to forty (40) years of age;
- A mammogram every two (2) years, or more frequently based on the recommendation of the woman’s practitioner, for women forty (40) to fifty (50) years of age; and
- A mammogram every year for women fifty (50) years of age and over.
BlueCare Tennessee provides coverage for Chlamydia screening according to the following guidelines, in compliance with Tennessee Code Annotated 56-7-2606:

- One (1) annual Chlamydia screening test for covered females from sixteen (16) to twenty-four (24) years of age; and
- One (1) annual Chlamydia screening test in conjunction with an annual pap smear* for covered females who are up to twenty-nine (29) years of age and older if the screening test is recommended by the Practitioner.

Special Counseling - Health habits, lifestyle issues, injury prevention, dental health, nutrition, etc.

Immunizations – Refer to Adult Immunization Schedule at [www.cdc.gov/vaccines/schedules/](http://www.cdc.gov/vaccines/schedules/).

*Pap smear every twelve (12) months for women within three (3) years of onset of sexual activity or age 21, whichever comes first.

Periodicity for Subsequent Visits

Ages 40-64 years

History - Every one (1) to three (3) years; past and family history, updated only.

Physical Exam - Every one (1) to three (3) years.

Laboratory - Pap smear* every one (1) to three (3) years beginning at age 21.

BlueCare Tennessee provides coverage for mammography screening for diagnostic purposes as recommended by a patient’s practitioner according to the following guidelines, in compliance with Tennessee Code Annotated 56-7-2502:

- A baseline mammogram for women thirty-five (35) to forty (40) years of age;
- A mammogram every two (2) years, or more frequently based on the recommendation of the woman’s practitioner, for women forty (40) to fifty (50) years of age; and
- A mammogram every year for women fifty (50) years of age and over.

Total cholesterol annually. Members with special risk factors; fasting glucose, VDRL urinalysis, chlamydia testing, gonorrhea culture, HIV testing, hearing, PPD, EKG, fecal occult blood/sigmoidoscopy /colonoscopy, bone mineral content.

Special Counseling - Injury prevention, dental health, skin protection from ultraviolet light, discussion of aspirin therapy in men and estrogen replacement in women.

Immunizations - Refer to Adult Immunization Schedule at [www.cdc.gov/vaccines/schedules/](http://www.cdc.gov/vaccines/schedules/).

*Pap smear every twelve (12) months for women within three (3) years of onset of sexual activity or age 21, whichever comes first. After three or more consecutive exams and 30 years or older with normal findings, pap smears can wait as long as five (5) years for the next screening, but Members should still go to the doctor regularly for a checkup.

Ages 65 and above

History - Every year; past and family history and functional status and symptoms of transient ischemia attacks, updated only.

Physical Exam - Physical exam, hearing and visual acuity every year.
Laboratory - Mammogram every twelve (12) months, thyroid indices (women), dipstick urinalysis, total cholesterol. Members with special risk factors: fasting glucose, PPD, EKG, Pap smear every one (1) to three (3) years, fecal occult blood/ sigmoidoscopy, and colonoscopy.

Special Counseling - Injury prevention, dental health, skin protection from ultraviolet light, discussion of aspirin therapy in men, estrogen replacement in women and glaucoma testing.

Immunizations - Refer to Adult Immunization Schedule at [www.cdc.gov/vaccines/schedules/](http://www.cdc.gov/vaccines/schedules/).

Guidelines for Periodic Health Assessments of Children

Periodic health assessment visits optimally should be scheduled according to TennCare Kids and/or American Academy of Pediatrics (AAP) Pediatric Preventive Care Guidelines and the PCP’s judgment.

Well-Care Guidelines for Children

Because each child is unique, these recommendations are designed for the care of children who have no important health problems and are developing normally. The recommendations should be modified for children with special health care needs or if disease or trauma manifests variations from normal. The AAP emphasizes the importance of very early professional intervention and the continuity of care based on individualized needs.

Note: See Section XX. TennCare Kids in this Manual for screening guidelines and billing instructions.

C. Preventive Care Services Billing Requirements

The State of Tennessee, Division of TennCare has identified certain procedures as Preventive Care Services. BlueCare/TennCareSelect covered Preventive Services are not subject to coinsurance or deductibles. Listed below are billing requirements for preventive services procedure codes. See TennCare Rule 1200-13-13-04 for additional details.

Preventive Care

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>99391</td>
</tr>
<tr>
<td>99382</td>
<td>99392</td>
</tr>
<tr>
<td>99383</td>
<td>99393</td>
</tr>
<tr>
<td>99384</td>
<td>99394</td>
</tr>
<tr>
<td>Initial Evaluation</td>
<td>Periodic Reevaluation</td>
</tr>
<tr>
<td>Age 1 Thru 4</td>
<td>Age 1 Thru 4</td>
</tr>
<tr>
<td>Age 5 Thru 11</td>
<td>Age 5 Thru 11</td>
</tr>
<tr>
<td>Age 12 Thru 17</td>
<td>Age 12 Thru 17</td>
</tr>
</tbody>
</table>

| Age 18 Thru 39       | Age 18 Thru 39       |
| Age 40 Thru 64       | Age 40 Thru 64       |
| Age 65 And Over      | Age 65 And Over      |

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Prenatal Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
</tr>
<tr>
<td>59410</td>
<td>Vaginal delivery only (with or without episiotomy, and/or forceps) including postpartum care</td>
</tr>
<tr>
<td>59430</td>
<td>Postpartum care only (separate procedure)</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care</td>
</tr>
<tr>
<td>59515</td>
<td>Cesarean delivery only including postpartum care</td>
</tr>
</tbody>
</table>

Counseling and/or Risk Factor Reduction Intervention

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>99401</td>
<td>~15 Minutes</td>
</tr>
<tr>
<td>99402</td>
<td>~30 Minutes</td>
</tr>
<tr>
<td>99403</td>
<td>~45 Minutes</td>
</tr>
<tr>
<td>99404</td>
<td>~60 Minutes</td>
</tr>
<tr>
<td>99411</td>
<td>~30 Minutes</td>
</tr>
<tr>
<td>99412</td>
<td>~60 Minutes</td>
</tr>
<tr>
<td>99413</td>
<td>~45 Minutes</td>
</tr>
</tbody>
</table>

Other Preventive Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77055</td>
<td>Mammography Screening</td>
</tr>
<tr>
<td>77056</td>
<td>Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.</td>
</tr>
<tr>
<td>77057</td>
<td>Administration of caregiver-focused health risk assessment (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.</td>
</tr>
<tr>
<td>92551</td>
<td>Screening test, pure tone, air only</td>
</tr>
<tr>
<td>92552</td>
<td>Pure tone audiometry (threshold); air only</td>
</tr>
</tbody>
</table>

Family Planning Services

If Family Planning Services are not part of a Preventive Service office visit, charges should be billed separately using individual Counseling and Risk Reduction codes shown above.

Vaccines for Children (VFC)

(Does not apply to CoverKids)

VFC is a federally funded program operated by the State of Tennessee’s Department of Health (DOH). All TennCare enrolled children 18 years of age and under are eligible for the VFC vaccines. These vaccines are available to any Provider who serves eligible Members.

If you provide care for BlueCare/TennCareSelect Members 0 – 18 years of age, you are eligible to receive free vaccine serums from the Tennessee Department of Health’s VFC Program. Your practice can receive payments for the administration of vaccines under the federal Vaccines for Children (VFC) program by registering with the Tennessee Immunization Information System (TennIIS). TennIIS is a statewide system managed by the Tennessee Department of Health to help ensure Tennesseans of all ages are properly immunized. The program allows health care Providers, pharmacists, schools and childcare organizations to access and update vaccination records. To learn more about TennIIS and VFC programs, please visit https://www.tennesseeiis.gov/tnsiis/.

If you are interested in enrolling in the VFC Program for the first time or would like to request a Starter Kit, please contact the VFC Enrollment team directly at VFC.Enrollment@tn.gov.

BlueCare Tennessee covers vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) through passage of VFC resolution. The ACIP includes in the Vaccines for Children program vaccines which are used to prevent the 16 diseases listed below; to be administered as provided in other VFC resolutions:
Diphtheria | Measles | Rotavirus
---|---|---
Haemophilus influenza type b | Meningococcal | Rubella
Hepatitis A | Mumps | Tetanus
Hepatitis B | Pertussis (whooping cough) | Varicella
Human Papillomavirus | Pneumococcal | 
Influenza | Poliomyelitis |


### Billing Guidelines

The appropriate Administration CPT® codes must be reported in addition to the vaccine procedure code. **Note:** CPT® guidelines should be followed for reporting administration services using add-on codes.

- Office visit code billed along with one or more immunization codes covered under the VFC is acceptable;
- Preventive visit code, billed along with one or more immunization codes covered under the VFC is acceptable;
- Therapeutic, Prophylactic and Diagnostic Injection CPT® codes should not be billed with the immunization codes covered under the VFC Program.

To encourage enrollment in Tennessee’s VFC program, BlueCare Tennessee reimburses $10.25 per vaccine for the administration of vaccines given to children ages 18 years and younger. Practitioners who choose not to participate in the VFC Program will not receive any reimbursement for the vaccines but will receive the same reimbursement for the administration of the vaccine that is paid to Providers who do participate in the VFC program.

The reimbursement rate for CPT® code 90460 recently increased for Providers delivering vaccines through the Vaccines for Children program. Effective March 1, 2019, Providers delivering vaccines to children covered by BlueCare and TennCare Select will receive reimbursement according to the standard BlueCare and TennCare Select fee schedule.

The Centers for Medicare & Medicaid Services (CMS) released new information regarding the Vaccines for Children (VFC) program and the CPT® vaccine administration codes 90460 and 90461. According to the Department of Health, reimbursement for the administration codes will continue to be based on a per-vaccine (per unit) basis and NOT on a per antigen or per component basis. Standard rates will be reimbursed for VFC administration code 90460 for those vaccines included in the VFC program. Reimbursement for the component administration code 90461 is $0 for the VFC program. Fee-for-service reimbursement will apply to the administration of vaccines not included in the VFC program. Reimbursement according to components will only be applied to those vaccines not available through the VFC program. Claims with no vaccine to match the administration fee will be denied with explanation code WB8: The number of administration services for these injections must equal injections billed.

Situations occur where children may have private health insurance and Medicaid as secondary insurance. These children will be VFC-eligible as long as they are enrolled in Medicaid. The options are described below:

**Option 1**
A Provider can administer VFC vaccine to these children and bill the Medicaid agency for the administration fee.

**Option 2**
A Provider can administer private stock vaccine and bill the primary insurance carrier for both the cost of the vaccine and the administration fee.
Practitioners are encouraged to perform and document all components of preventive health screenings and to use the appropriate codes as directed by TennCare.

D. Guidelines of Periodic Health Assessments Records

Health Education – The following topics should be addressed as indicated:

**Infancy**
- Appropriate use of PCP in maintaining or improving health status.
- Infant development, behavior and care.
- Infant stimulation.
- Parenting skills/sibling issues.
- Need for immunizations and information on preventable childhood diseases.
- Nutritional information and education specific to the nutritional needs of the infant, including delayed introduction of solids and weaning from the bottle or breast to the cup.
- Maternal nutrition if mother is breast feeding.
- Therapeutic dietary counseling for identified high-risk conditions that respond to diet therapy, if indicated and provided by the Provider.
- Recognition and management of illness, including recognition of signs and symptoms of child and sexual abuse.
- Importance of obtaining and maintaining continuous, comprehensive health care for mother and child, including identification of available resources to help with such problems as sudden illness or breast feeding difficulties.
- Automobile restraints for infants, and general accident prevention (especially home accidents and accidental poisonings).
- Effect of children of parental smoking, use of alcohol, other drugs, and other health-damaging behaviors.
- Relevant topics in response to parental concerns.
- Hygiene and first aid.
- Child care arrangements.

**Pre-School and School Age**
- Appropriate use of PCP in maintaining or improving health status.
- Explanation of purpose and sequence of procedures to be provided during the visit.
- Clinical findings of the visit.
- Physical, including sexual, and emotional growth and development, appropriate to age and gender of child.
- Interpersonal relations with family members and peers, appropriate to age of child.
- Parenting skills.
- Assistance to parent/caregiver in teaching the child about human reproduction and sexuality, appropriate to age of child.
- Management of stress associated with caring for young children, appropriate to age of child.
- Need for immunizations and information on preventable childhood diseases.
- Nutritional need of the child, including development of good eating habits.
- Therapeutic dietary counseling for identified conditions that respond to diet therapy.
- Childhood antecedents of adult illness.
- Recognition and management of illnesses, including recognition of signs and symptoms of child and sexual abuse.
Development of positive health habits.
Dental health.
Physical activity, exercise and sleep, appropriate to age.
Automobile restraints for children and other general accident prevention (especially home accidents, accidental poisoning, sports injuries).
Environmental hazards.
Danger of smoking by older children and effects on children of parental smoking, use of alcohol and drugs and other health damaging behaviors.
Hygiene.
First aid.
Child care arrangements.
Other educational and counseling appropriate to parent/caregiver or Member’s needs or concerns.

Adolescent/Young Adult
- Appropriate use of PCP in maintaining or improving health status.
- Confidentiality of services.
- Explanation of purpose and sequence of procedures to be done during the visit.
- Clinical findings of the visit.
- Physical — including sexual and emotional — growth and development, appropriate to age.
- Interpersonal relations with family members and peers.
- Management of stress/feelings.
- Antecedents of adult illness.
- Need for immunizations and information on preventable diseases.
- Recognition and management of illnesses common during adolescence, including recognition of signs and symptoms of child and sexual abuse.
- Therapeutic dietary counseling for identified conditions that respond to diet therapy.
- Development of positive health habits.
- Dental health.
- Physical activity, exercise and sleep.
- Automobile restraints use and other general accident prevention (especially home accidents, substance use/abuse, sports injuries).
- Effects of health-damaging behaviors, including use of tobacco, alcohol and other drugs.
- Environmental hazards.
- Hygiene.
- First aid and survival techniques for emergency situations.
- Speech and hearing consultations.
- Family planning.
- Human reproduction and sexuality.
- Prenatal care for pregnant adolescents.
- Planning for the future.
- Other education and counseling appropriate to Member’s needs/concerns.

Dental Preventive Care
Dental services, which are required pursuant to TennCare Kids screenings for persons under age 21, shall be provided in accordance with the latest periodicity schedule set forth by the American Academy of Pediatric Dentistry and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry. Dental benefits are managed by the state’s contracted dental benefits manager. On Oct. 1, 2013, DentaQuest became the dental benefits manager for TennCare Members under the age of 21. (See Section XX. TennCare Kids in this Manual.)
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XV. Behavioral Health Care Services

BlueCare Tennessee facilitates the active partnerships that are essential to improving the health of BlueCare and TennCare Select populations.

Our Care Management programs support effective and efficient integration of medical and behavioral health services through a variety of joint coordination mechanisms within our Population Health Management programs.

A. Policies and Procedures Requirements

BlueCare requires behavioral health Providers of ALL LEVELS OF CARE to have specific policies and procedures to address:

- Ongoing staff training for both licensed and unlicensed staff,
- Supervision of all non-licensed staff, including documentation of supervision, and
- A specific policy for the protection of substance use disorder information in accordance to 42 CFR Part 2.

Additional policy and procedure requirements apply to SPECIFIC LEVELS OF CARE, as follows:

Child/Adolescent Residential Treatment Centers (RTCs)

- Staff training within ninety (90) days of hire to include knowledge of the population served, management of disruptive behaviors, physical restraint procedures and techniques, and care in relation to child development,
- Data collection and analysis of the use of physical restraints in order to identify patterns/problem areas for quality improvement purposes,
- Supervision and safety of residents that is appropriate for the population being served, and
- Compliance with all applicable State and accreditation entity regulations.

Inpatient Psychiatric Service

- Acceptance of voluntary and involuntary admissions,
- Accreditation by The Joint Commission,
- Evaluation for mental and substance use disorder, as Medically Necessary, and
- Discharge planning for needed and appropriate behavioral health follow-up services.

Intensive Outpatient Program

- Member attendance and non-compliance with treatment.

Outpatient Services

- The capacity to render short-term crises stabilization and long-term treatment and rehabilitation,
- The provision of on-site services that include, but are not limited to, intensive outpatient services, and partial hospitalization,
- Therapy and off-site services that include, but are not limited to, intensive in-home service for children and youths and home and community treatment for adults.
## B. Covered Behavioral Health Services

(This section does not apply to CoverKids)

Benefits are available for clinical assessment, diagnosis, and referral, as well as for inpatient and outpatient services for treatment of behavioral health disorders (mental and substance use disorder).

The following grid lists behavioral health care Covered Services for BlueCare and TennCareSelect Members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Benefit Limit/Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric inpatient hospital services (including physician services)</td>
<td>As Medically Necessary.</td>
</tr>
<tr>
<td>24-Hour psychiatric residential treatment services</td>
<td>- Medicaid/Standard Eligible, age 21 and older: as Medically Necessary.</td>
</tr>
<tr>
<td></td>
<td>- Medicaid/Standard Eligible, Under age 21 years: as Medically Necessary.</td>
</tr>
<tr>
<td>Outpatient mental health services (including physician services)</td>
<td>As Medically Necessary.</td>
</tr>
<tr>
<td>Inpatient, residential &amp; outpatient substance use disorder benefits¹</td>
<td>Medicaid/Standard Eligible, Age 21 and older: As Medically Necessary.</td>
</tr>
<tr>
<td></td>
<td>Medicaid/Standard Eligible, Under age 21: Covered as Medically Necessary.</td>
</tr>
<tr>
<td>Behavioral Health Intensive Community-Based Treatment</td>
<td>As Medically Necessary.</td>
</tr>
<tr>
<td>Psychiatric rehabilitation services</td>
<td>As Medically Necessary.</td>
</tr>
<tr>
<td>Behavioral health crisis services</td>
<td>As Necessary.</td>
</tr>
<tr>
<td>Lab and X-ray services</td>
<td>As Medically Necessary.</td>
</tr>
<tr>
<td>Non-emergency medical transportation (including non-emergency ambulance transportation)</td>
<td>As necessary to get an enrollee to and from Covered Services.</td>
</tr>
</tbody>
</table>

¹ When Medically Appropriate, services in a licensed substance use disorder residential treatment facility may be substituted for inpatient substance use disorder services. Methadone clinic services are not covered for adults.
Population Health Management

BlueCare Tennessee’s Population Health Management Program helps Members stay healthy, address health risks, and manage their chronic conditions, such as schizophrenia, bipolar disorder, and major depressive disorder. Population Health Management services include outreach, health education, care coordination, case management, and more. Services are available to BlueCare, TennCare Select, and SelectCommunity Members at no extra cost.

BlueCare evaluates our entire Member population for risk factors (not disease categories) to identify Enrollees who may benefit from particular Population Health Management services. We encourage Providers to refer Members to population health services, as needed. To refer Members, call 1-888-416-3025.

Additional information on our Population Health Management program can be found in Section X of this Manual.

Care Management

BlueCare’s Care Management program identifies and assesses Members who may benefit from community-based management services. BlueCare Tennessee Care Management may contact behavioral health Providers to facilitate care coordination for high-risk Members.

Member Education and Outreach

BlueCare Tennessee conducts health, education, and outreach programs and activities aimed to enhance the Member’s health and well-being.

Activities include:

- New Member Education (New Member Welcome call and New Member Welcome packet)
- Quarterly Newsletters
- Tennessee Quarterly Newsletters
- Special Screening events
- Focused Behavioral Health events

Clinical Practice Guidelines

Providers may reference Best Practice Guidelines and the Managed Care Standards for the Delivery of Behavioral Health Services online at https://www.tn.gov/behavioral-health/for-providers.html.

Providers may also reference additional Behavioral Health information and guidelines at:

https://www.bcbst.com/providers/tools-resources.page
https://www.bcbst.com/providers/Behavioral-Health-Toolkit/index.page

Effective January 1, 2015, BlueCare Tennessee adopted MCG and modified MCG guidelines. These guidelines can be referenced at:

Medical Necessity Determinations

BlueCare Tennessee considers the individual needs of each Member when making Medical Necessity determinations for Covered Services. We also consider availability of appropriate service alternatives that exist within the region.

BlueCare determines Medical Necessity on a case-by-case basis using established and approved criteria for behavioral health disorders. Timeframes for determining Medical Necessity are based on National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and State of Tennessee timeliness standards. Providers who do not submit requested medical information for the purposes of making a Medical Necessity determination for a service shall not be entitled to payment for that service. BlueCare Tennessee can impose financial penalties on a Provider who does not comply with an information request for appeals.

Second Opinions

BlueCare Tennessee provides benefits for a second opinion (in any situation where there is a question concerning diagnosis) when requested by a Member, parent, or legally appointed representative.

Use of Cost Effective Alternatives

BlueCare Tennessee uses non-covered alternative services if the use of such services is Medically Appropriate and cost effective. This may include the use of hotels or a nursing facility.

Treatment Planning

Providers are encouraged to use best practice guidelines. Consistent with this notion are those principles and guidelines outlined in the Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions located online at https://www.store.samhsa.gov/product/Shared-Decision-Making-in-Mental-Health-Care/SMA09-4371. Implicit in these practice guidelines are the principles of hope, empowerment, and self-determination as each person or family articulates a vision and begins to map a path to recovery. Although there remains some ambiguity about the meaning of recovery and resilience, there is an emerging consensus that a commitment to creating and using person-centered treatment plans in everyday practice is perhaps the most powerful and effective approach to ensuring recovery-oriented services.

Treatment Record Requirements

Providers are expected to develop an initial treatment plan within thirty (30) days of the start date of service and update it every six (6) months or more frequently, as clinically appropriate for outpatient programs. Evidence of an individualized treatment plan includes, but is not limited to, the following documentation:

- A Case Formulation Statement that hypothesizes the Member’s primary problem(s), states the desired treatment outcomes, describes the therapeutic approach to treatment, and proposes interventions toward desired outcomes;
- Identified problems for which the Member is seeking treatment;
- DSM diagnoses, primary and secondary;
- Measurable, attainable, age-appropriate goals and objectives related to the identified problems;
- Target dates for completion of goals/objectives;
- Information regarding the Member’s strengths used to develop strengths-based plan;
- Services to be used for each goal or objective (e.g., medication management, therapy, community-based treatment services);
Evidence of Member’s involvement in treatment planning. (*Fulfilling this requirement means that each initial treatment plan and subsequent treatment plan review is signed by a Member, family member, or legally appointed representative.*)

Progress notes for each service contact documenting the date and time of service, duration/end time of service, the type of service provided, a summary of treatment interventions used, the treatment plan goals and objectives addressed in the session, and the name and credentials of rendering service Provider.

Documentation of coordination of care efforts and communications with PCPs, other outside Providers, agencies, judicial system, Member support system, or any other person or entity involved in the Member’s treatment.

Evidence of discharge planning activities to include discharge plans, dates of follow-up appointments, and referrals to other Providers.

A discharge summary is completed and documented following discharge from service (see program descriptions for time frame requirements).

For Providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate, for each of the different services provided to the Member.

All treatment records must be legible, maintained in a detailed and organized manner, and available at the site where covered services are rendered. Treatment records for ALL LEVELS OF CARE must contain:

**Identifying Member Information:**
- Member name and at least one other piece of identifying information on every page or electronic screen of treatment record. (date of birth, Member ID#, address)
- Member contact information including address and phone number
- Employment or school information
- Marital status
- Legal status (including state custody)
- Guardianship and/or conservatorship, if applicable
- Declaration for Mental Health Treatment form status

**Consent Forms Signed by Member/Parent/Guardian:**
- Consent for treatment
- Informed consent for prescribed medications
- Release of information forms, updated annually, for Member’s PCP, for other behavioral health Providers, and for any other Providers or agencies relevant to coordination of care
- For Members with no PCP, documentation must reflect efforts to help a Member to obtain a PCP
- Release of information form for MCO or payer, communicating to member that Provider will share service participation and treatment progress with MCO
- For adolescents ages 16 and older, a consent or refusal to discuss behavioral health issues with a parent/guardian
- Acknowledgement of review of patient rights and responsibilities

To equip Members with the information they need to provide informed consent, when residential treatment is being considered for children and adolescents BlueCare Tennessee expects Providers to inform children and adolescents and their parent(s) or legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Likewise, when voluntary inpatient treatment is being considered for adults, BlueCare Tennessee expects Providers to inform them or their legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.
Medication Information Documenting:
- All medications prescribed (psychotropic medications as well as medications for other physical health conditions), the dosages of each, and the dates of initial prescription and refills;
- If medications are prescribed by an outside Provider, the prescriber is identified;
- Any medication allergies or adverse reactions are clearly noted; and
- For Members being considered for psychotropic treatments, documentation must reflect evidence of informing the Member and parent or guardian of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

Current Medical Information and Medical History:
- A health assessment that includes medical history, screening for current medical problems, currently prescribed medications, and medication history;
- Medication allergies, adverse reactions, and relevant medical conditions are clearly documented as present or absent; and
- Documentation for Children/Adolescents regarding prenatal and perinatal events along with a complete developmental history (physical, psychological, social, intellectual, and academic).

Psychiatric Information and Psychiatric History:
- Identification of previous Providers and treatment services;
- Approximate dates of service for previous Providers and treatment services;
- Information regarding outcomes of previous treatment services;
- A mental status evaluation to be completed that includes, at a minimum, an assessment of appearance, affect/mood, speech, thought content, judgement/insight, attention/concentration, and memory;
- A DSM diagnosis consistent with current symptoms;
- Information addressing Member-specific cultural considerations;
- Information regarding the Member’s list of strengths;
- A substance use assessment that screens for frequently used over-the-counter medications, alcohol, tobacco, and other drugs and history of prior alcohol and drug treatment episodes (recommended screening tools are available at http://bluecare.bcbst.com);
- Current risk assessment (imminent risk of harm, suicidal or homicidal ideation/intent, elopement potential) clearly documented and updated according to written protocols; and
- A crisis plan relevant to Member’s risk potential that includes individualized steps for prevention or resolution of crisis. This plan should include, but is not limited to:
  - Identifying crisis triggers;
  - Steps to prevent, de-escalate, or defuse crisis situations;
  - Names and phone numbers of contacts who can assist Member in resolving crises; and
  - The Member’s preferred treatment options in the event of a crisis.

Policies and Procedures

Supervision and Training for Non-licensed Staff

Supervision and Training for Non-licensed Staff

- Non-licensed staff
  - When individuals providing behavioral health treatment services are not required to be licensed or certified, the facility must provide documentation that the individuals are appropriately educated, trained, qualified, supervised, and competent to perform their job responsibilities.
Non-licensed/Non-independently licensed – Master’s Level Clinical Services
- It is the expectation that ongoing supervision will be provided by Mental Health/Substance Use facilities/CMHC Providers who employ non-licensed clinical staff that complete clinical activities, such as clinical assessments and psychotherapy. The facility should ensure that all non-licensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the non-credentialed clinician to review the treatment and/or services provided to Members.
- Under the supervision of an independently licensed clinician, non-licensed master’s level clinicians who render behavioral health professional services shall receive clinical supervision specific to the rendered service. The supervision will include a minimum of direct supervision during service initiation, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory Practitioner.
  - Direct supervision means the supervising Provider must be immediately available (i.e., in person, by phone or through telehealth/video conferencing) to furnish assistance and direction throughout the rendered service and may include the Supervisor’s review and signing of the treatment plan during service initiation.
  - General supervision means the service is performed under the supervisory clinician’s overall direction and control but his or her presence is not required during the performance of the intervention.

Additional record requirements apply to SPECIFIC LEVELS OF CARE, as follows:

Child/Adolescent Residential Treatment Centers:
- An intake, initial evaluation, and diagnostic assessment completed within 2 hours of admission
- An initial treatment plan completed within the first seventy-two (72) hours of admission, and an updated treatment plan at least every thirty (30) days or upon completion of the stated goals/objectives
- Progress notes to be documented daily for each therapeutic contact and the Member’s individual progress
- Documentation of consent by parent/guardian or Member (if 16 years of age or older) to all medication changes
- Documentation of seclusion/restraint events, notifications, and debriefings with Member and staff
- Medication administration record (MAR)
- Documentation of coordination with aftercare Providers (including education Providers) throughout the residential stay, and particularly coordination with Providers as the discharge date approaches that includes aftercare appointments and sharing of relevant clinical information for continuity of care; and
- Discharge summary completed within five (5) business days of Member discharge which includes Member’s condition at time of discharge or transfer, the reason for discharge or transfer, aftercare appointments, and signature of person preparing the summary

Intensive Outpatient Program (mental health and substance use disorders):
- An intake, initial evaluation, and diagnostic assessment and an initial individualized treatment plan must be completed and documented within three (3) days of treatment
- Updated treatment plan at least every eight (8) treatment sessions
- Progress notes for each therapeutic contact, including group sessions, to include date, start and finish times, level of Member participation, daily risk assessment, and signature of service Provider
- Documentation of evaluation for mental health and substance use disorder services as Medically Necessary and evidence of the provision of needed services with appropriate behavioral health follow-up services planned
Outpatient Service Providers:

- An intake, initial evaluation, or diagnostic assessment completed within the first thirty (30) calendar days of initiation of services, and to be updated as needed, but annually at minimum
- An initial treatment plan completed within the first thirty (30) calendar days of initiation of services, and an updated treatment plan at least every six (6) months
- A progress note completed for each service contact
- Documentation of communication with Member’s PCP and other behavioral health Providers within two (2) weeks of the intake/diagnostic assessment; annual updates to those Providers, and notification of discharge from services to those Providers; all communication to other Providers must include a summary of treatment services, including medications, and any changes to treatment since the previous communication; communication with the PCP or other medical Provider must include a request for information to be sent back, to include at a minimum, a medication list
- A discharge/transfer summary that includes Member’s condition at the time of discharge/transfer, the reason for discharge/transfer, aftercare recommendations or appointments as applicable, and the signature of person preparing the summary

Substance Use Disorder Services Providers (Inpatient, Residential, & Outpatient):

- For detoxification services, documentation of supervision by a Tennessee-licensed Physician with a minimum of daily re-evaluations by a Physician or a registered nurse.

Diagnosis

Diagnostic and Statistical Manual of Mental Disorders (DSM) codes are used for authorization of care, while International Classification of Diseases (ICD) codes are used for billing.

DSM codes are maintained and updated by the American Psychiatric Association and ICD codes are owned and published by the World Health Organization (WHO).

BlueCare Tennessee provides regular updates regarding ICD and DSM codes in the monthly BlueAlert newsletter.

Care Coordination

Members are frequently in treatment with multiple Providers and other support professionals. Members may also want to include family members or other individuals in their treatment plan. Care coordination is a deliberate activity to ensure clear communication among everyone involved in a Member’s care, reinforce support, and improve outcomes for the Member and the entire team.

Although communication is a responsibility shared by the Member and all the Member’s Providers, care coordination is most successful when a single person assumes the role of facilitating and sharing communications, tracking progress toward health goals, and linking Members to appropriate services as their needs change. BlueCare Tennessee can assist in this role, as can community-based treatment service Providers. Members can request a care coordinator by calling 1-888-416-3025, Monday through Friday, 8 a.m. to 6 p.m. (ET).

Providers should screen for physical health issues and provide appropriate referrals and coordination of care as needed following this screening. Screening for physical health issues and coordination with primary care Physicians should be completed on intake and annually thereafter for each Member. BlueCare will conduct audits to monitor compliance with this standard.

The outpatient Provider should be involved in inpatient or residential admission processes, when possible. If the outpatient Provider is not involved, the outpatient Provider should be notified as soon as possible about the admission.
A Member must not be discharged from an inpatient or residential treatment facility without a discharge plan in place. Discharge plans should be developed with Member participation. We recommend holding a discharge planning conference with the BlueCare or TennCareSelect case manager, the community care coordinator, all outpatient Providers, and the inpatient team.

Transitions of Care

BlueCare Tennessee ensures that Members discharged from inpatient and residential behavioral health treatment programs have discharge appointments, keep appointments, and are connected to additional resources that support their recovery. These services include connecting Members to:
- housing;
- social services;
- social supports; and
- other community services.

Discharge appointments should consider the need for follow up regarding medication management, Behavioral Health Intensive Community-Based Treatment Services, Tennessee Health Link (THL) services, behavioral health, and medical services. Providers are encouraged to assess for the need for community-based treatment or THL services. If found to be Medically Necessary, the community-based treatment or THL Provider should be involved in discharge planning, and the follow up medical appointment should be scheduled to occur within seven (7) days of discharge. A plan for medication compliance must be part of the discharge plan. Appropriate housing must be secured prior to discharge.

Prior Authorizations

Psychological testing, electroconvulsive therapy, and transcranial magnetic stimulation, along with other psychiatric intensive outpatient services and psychiatric partial hospitalization require prior authorization. Prior authorization is not required for In-Network Substance Use Disorder intensive Outpatient Program or Partial Hospitalization Program. Inpatient and higher levels of care also require prior authorization. Note: Effective April 1, 2017, Crisis Stabilization Unit stays require notification only.

A prior authorization may be retroactively denied by BlueCare Tennessee if BlueCare Tennessee subsequently determines that (1) the health care services rendered were not included as Covered Services under the applicable Benefit Plan; (2) such services were not Medically Necessary; (3) the Member was ineligible for such services at the time the services were rendered; or (4) the information submitted with the prior authorization request was not accurate or complete.

- Providers can submit requests by telephone, mail or the Web through Availity at https://www.bcbst.com/providers/index_page?nav=header.
- Prior authorization requests for behavioral health services (other than inpatient) may be submitted via fax to 1-866 320-3800 or via Availity at http://bluecare.bcbst.com or https://www.bcbst.com/providers.
- Prior authorization requests for behavioral health services can also be obtained by calling 1-888-423-0131 for BlueCare and 1-800-711-4104 for TennCareSelect.

Note: Prior authorization requests for behavioral health services for CoverKids should continue to be submitted via fax to 1-800-851-2491 (for services other than inpatient) or by calling the Provider Service Line at 1-800-924-7141. Mail requests to:

BlueCare/TennCareSelect
UM Support, CH 4.3
1 Cameron Hill Circle
Chattanooga, TN 37402

Rev 06/19
Provider Initiated Notice

Note: Under no circumstances should a Member be discharged prior to receiving a letter outlining their right to appeal the Provider’s decision to discharge.

The Division of TennCare requires that all Members being discharged from any Behavioral Health service be notified of their rights to appeal that discharge decision. (See Section VII. Member Policy in this Manual for more information on Member rights.) Providers are required to notify the Managed Care Organization (MCO) of any Provider-initiated discharge by submitting a Provider Initiated Notice (PIN) form at least two (2) days prior to the discharge. The MCO is responsible for providing the Member with a letter that outlines his or her appeal rights. An electronic copy of the PIN is available on the company website, http://bluecare.bcbst.com. Also available is a web-based utility for submitting PINs through Availity, BlueCross BlueShield of Tennessee’s secure area on its websites, http://bluecare.bcbst.com and www.bcbst.com.

Submit PINs by fax to 1-800-859-2922.

Levels of Service

For levels of care and program descriptions, please refer to the following link: https://www.bcbst.com/providers/tools-resources.page

All behavioral health services shall be rendered in a manner that supports the recovery of persons experiencing mental illness and enhance the development of resiliency of children and families who are impacted by mental illness, serious emotional disturbance, and/or substance use disorders. Recovery is a consumer-driven process in which consumers are able to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life with a disability.

Intensive Community Based Treatment (ICBT)

Behavioral Health Intensive Community-Based Treatment (ICBT) Services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. The provision of ICBT services focuses on adults and youth with complex needs including individuals who are at high risk of future hospitalization or placement out of the home and require both community support and treatment interventions. ICBT services shall be rendered through a team which shall include a therapist and care coordinator who work under the direct clinical supervision of a licensed behavioral health professional. The primary goal of these services is to reach an appropriate point of therapeutic stabilization so the individual can be transitioned to less in home based services and be engaged in appropriate behavioral health office based services approach.

ICBT services are supportive services provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. ICBT services are consumer-centered, consumer-focused, and strengths-based, with services provided in a timely, appropriate, effective, efficient, and coordinated fashion. It consists of activities performed by a community-based services team to support clinical services. Community-based services staff members assist in ensuring individual/family access to services.

ICBT services are available 24-hours-a-day, 7-days-a-week. The service is not time limited. ICBT services are considered preventive and are not subject to Member copayment amounts.

BlueCare Tennessee ensures ICBT services are rendered in accordance with all service components and guidelines herein.

ICBT services should include, at a minimum, the following elements and services as clinically appropriate:
System of Care principles
- Direct clinical supervision
- Evidenced-based comprehensive assessments and evaluations
- An average of one to two (1-2) visits per week for individual therapy, family therapy, care coordination

Intensive Community Based Treatment Services shall be outcome-driven, including, but not limited to these treatment outcomes:

- Strengthened family engagement in treatment services
- Increased collaboration among formal and informal service Providers to maximize therapeutic benefits
- Progress toward child & family goals
- Increased positive coping skills
- Increased family involvement in the community
- Developed skills to independently navigate the behavioral health system

Intensive Community-Based Treatment Services include CTT, CCFT, and PACT treatment models as described below:

**Continuous Treatment Team (CTT)**

CTT is a coordinated team of staff (to include Physicians, nurses, case managers, and other therapists as needed) who provide a range of intensive, care coordination, treatment, and rehabilitation services to adults and children and youth. The intent is to provide intensive treatment to adults and families of children and youth with acute psychiatric problems in an effort to prevent removal from the home to a more restrictive level of care. An array of services are delivered in the home or in natural settings in the community, and are provided through a strong partnership with the family and other community support systems. The program provides services including crisis intervention and stabilization, counseling, skills building, therapeutic intervention, advocacy, educational services, medication management as indicated, school based counseling and consultation with teachers, and other behavioral health services deemed necessary and appropriate.

**Comprehensive Child and Family Treatment (CCFT)**

CCFT services are high intensity, time-limited, therapeutic services designed for children and youth to provide stabilization and deter from out-of-home placement. There is usually family instability and high-risk behaviors exhibited by the child/adolescent. CCFT services are concentrated on child, family, and parental/guardian behaviors and interaction. CCFT services are more treatment oriented and situation specific with a focus on short-term stabilization goals.

**Program of Assertive and Community Treatment (PACT)**

PACT is a service delivery model for providing comprehensive community-based treatment to adults with severe and persistent mental illness. It involves the use of a multi-disciplinary team of mental health staff organized as an accountable, mobile mental health agency or group of providers who function as a team interchangeably to provide the treatment, rehabilitation and support services persons with severe and/or persistent mental illnesses need to live successfully in the community. The service components of PACT include:

1) Services targeted to a specific group of individuals with severe mental illness;
2) Treatment, support and rehabilitation services provided directly by the PACT team;
3) Sharing of responsibility between team members and individuals served by the team;
4) Small staff (all team staff including case managers) to individual ratios (approx. 1 to 10);
5) Comprehensive and flexible range of treatment and services;
6) Interventions occurring in community settings rather than in hospitals or clinic settings;
7) Twenty-four (24) hour-a-day availability of services; and
8) Engagement of individuals in treatment and recovery.

**Tennessee Health Link (THL)**

Tennessee Health Link is a team of professionals associated with a mental health clinic or other behavioral health Provider who provides whole-person, patient-centered, coordinated care for an assigned panel of Members with behavioral health conditions. Members who would benefit from Tennessee Health Link will be identified based on diagnosis, health care utilization patterns, or functional need. They will be identified through a combination of claims analysis and Provider referral.

Health Link professionals will use care coordination and patient engagement techniques to help Members manage their health care across the domains of behavioral and physical health, including:

- Comprehensive care management (e.g., creating care coordination and treatment plans)
- Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health Providers)
- Health promotion (e.g., educating the patient and his/her family on independent living skills)
- Transitional care (e.g., participating in the development of discharge plans)
- Patient and family support (e.g., supporting adherence to behavioral and physical treatment)
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through)

**C. Psychiatric Rehabilitation Services**

Psychiatric rehabilitation is an array of consumer-centered recovery services designed to support the individual in the attainment or maintenance of his or her optimal level of functioning. These services are designed to capitalize on personal strengths, develop coping skills and strategies to deal with deficits and develop a supportive environment in which to function as independently as possible on the individual's recovery journey.

**Service Components**

Services included under psychiatric rehabilitation are as follows:

**Psychosocial Rehabilitation**

Psychosocial Rehabilitation is a community-based program that promotes recovery, community integration, and improved quality of life for Members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives. The goal of Psychosocial Rehabilitation is to support individuals as active and productive members of their communities through interventions developed with a behavioral health professional or certified peer recovery specialist, in a non-residential setting. These interventions are aimed at actively engaging the Member in services, and forming individualized service plan goals that will result in measurable outcomes in the areas of educational, vocational, recreational and social support, as well as developing structure and skills training related to activities of daily living. Such interventions are collaborative, person-centered, individualized, and ultimately results in the Member's wellness and recovery being sustainable within the community without requiring the support of Psychosocial Rehabilitation. Psychosocial Rehabilitation must meet Medical Necessity criteria and may be provided in conjunction with routine outpatient services.

Psychosocial Rehabilitation services vary in intensity, frequency, and duration in order to resolve the Member's ability to manage functional difficulties.
Supported Employment

Supported employment consists of evidence based practices (e.g., individual placement and support) to assist individuals to choose, prepare for, obtain, and maintain gainful employment that is based on individuals’ preferences, strengths, and experiences. This service also includes support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Peer Recovery Services

Peer recovery services are designed and delivered by people who have lived with behavioral health issues. A Certified Peer Recovery Specialist (CPRS) is someone who has self-identified as being in recovery from mental illness, substance use disorder, or co-occurring disorders of both mental illness and substance use disorder. In addition, a Certified Peer Recovery Specialist has completed specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to provide peer recovery services based on the principles of recovery and resiliency. Certified Peer Recovery Specialists can provide support to others with mental illness, substance use disorder, or co-occurring disorder and help them achieve their personal recovery goals by promoting self-determination, personal responsibility, and the empowerment inherent in self-directed recovery.

Under the direct clinical supervision of a licensed behavioral health professional, peer recovery services provided by a Certified Peer Recovery Specialist may include: assisting individuals in the development of a strengths-based, person-centered plan of care; serving as an advocate or mentor; developing community support; and providing information on how to successfully navigate the behavioral health care system. Activities which promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills are provided so individuals can educate and support each other in the acquisition of skills needed to manage their recovery and access resources within their communities. Services are often provided during the evening and weekend hours.

Family Support Services

Family support services are used to assist other caregivers of children or youth diagnosed with emotional, behavioral, or co-occurring disorders, and are provided by a Certified Family Support Specialist under the direct clinical supervision of a licensed behavioral health professional. A Certified Family Support Specialist is a person who has previously self-identified as the caregiver of a child or youth with an emotional, behavioral or co-occurring disorder and who has successfully navigated the child-serving systems to access treatment and resources necessary to build resiliency and foster success in the home, school, and community. This individual has successfully completed and passed training recognized by the Tennessee Department of Mental Health and Substance Abuse Services on how to assist other caregivers in fostering resiliency in their child based on the principles of resiliency and recovery; and has received certification from the Tennessee Department of Mental Health and Substance Abuse Services as a Certified Family Support Specialist.

These services include assisting caregivers in managing their child’s illness and fostering resiliency and hope in the recovery process. These direct caregiver-to-caregiver support services include, but are not limited to, developing formal and informal supports, assisting in the development of strengths-based family and individual goals, serving as an advocate, mentor, or facilitator for resolution of issues that a caregiver is unable to resolve on his or her own, or providing education on system navigation and skills necessary to maintain a child with emotional, behavioral or co-occurring disorders in their home environment.

Illness Management & Recovery

Illness management and recovery services are a series of weekly sessions with trained mental health Practitioners that help participants develop personal strategies for coping with mental illness and promoting recovery. Illness management and recovery is not limited to one curriculum but is open to all evidenced-based and/or best practice classes and programs such as WRAP (Wellness Recovery Action Plan).
Supported Housing

Supported housing services refer to transitional services rendered at facilities that provide behavioral health staff supports for individuals who require treatment services in a highly structured, safe, and secure setting. Supported housing services are for TennCare Priority Enrollees and are intended to prepare individuals to live independently in a community setting. At a minimum, supported housing services include coordinated and structured personal care services to address the individuals’ behavioral and physical health needs in addition to fifteen (15) hours per week of psychosocial rehabilitation services to assist individuals in achieving recovery and resiliency-based goals and developing the life skills necessary to live independently in a community setting. The required fifteen (15) hours per week of psychosocial rehabilitation is not inclusive of the psychosocial rehabilitation services received in day programs. Supported housing services do not include the payment of room and board.

D. Crisis Services

Behavioral health crisis services shall be rendered to individuals with a mental health or substance use/abuse issue when there is a perception of a crisis by an individual, family member, law enforcement, hospital staff or others who have closely observed the individual experiencing the crisis. Crisis services are available twenty-four (24) hours-a-day, seven (7) days-a-week. Crisis services include twenty-four (24) hour toll-free telephone lines answered in real time by trained crisis specialists and face-to-face crisis services including, but not limited to: prevention, triage, intervention, evaluation/referral for additional services/treatment, and follow-up services. Certified Peer Recovery Specialists and/or Certified Family Support Specialists shall be utilized in conjunction with crisis specialists to assist adults and children in alleviating and stabilizing crises and promote the recovery process as appropriate. Behavioral health crisis service Providers are not responsible for prior authorizing emergency involuntary hospitalizations.

The Mental Health Crisis Response Services - Community Face-to-Face Response Protocols provide guidance for calls that are the responsibility of a crisis response service to determine if a face-to-face evaluation is warranted and those that are not the responsibility of the crisis response service. These Protocols were developed to help ensure that consumers who are experiencing a behavioral health crisis and have no other resources receive prompt attention. All responses are first determined by clinical judgment.

Guidance for All Calls:

- For calls originating from an Emergency Dept., telehealth is the preferred service delivery method for the crisis response service.
- After determining that there is no immediate harm, ask the person if he or she can come to the closest walk-in center.
- All admissions to state-owned RMHIs require a face-to-face evaluation by a Mandatory Pre-screening Agent (MPA). It is recommended that a MPA that is employed by a crisis team be consulted for all involuntary admissions.
- If a MPA not employed by a crisis response service is available, there may be no need for a crisis evaluation by mobile crisis.

For all other calls, unless specified in the Protocols, if a person with mental illness is experiencing the likelihood of immediate harm then a response is indicated.

Crisis Stabilization

Crisis stabilization services provide immediate shelter to BlueCare and TennCare Select Members with mental health/ or behavioral problems who need of emergency stabilization. These services are more intensive than regular behavioral health crisis services in that they provide more secure environments, highly trained staff, and typically allow for longer stays.
E. Psychiatric Residential Treatment Services

BlueCare/TennCareSelect requests for Psychiatric Residential Treatment services will be reviewed using the Request for Services form located on the BlueCare Tennessee Provider website at https://bluecare.bcbst.com/providers/forms.html.

Complete the form in full prior to submitting the request. If some information (such as psychological testing) is not available, note that on the form.

Additional pages can be attached, but please clearly identify the applicable section and add the Member’s name and Member identification number to each attached page.

Requests for Psychiatric Residential Treatment Facility (PRTF) services are considered non-urgent. BlueCare/TennCareSelect will make a decision within fourteen (14) days of the date of the request. If we request additional information and do not receive it, we will base decisions on the information presented. Clinical Care Managers will contact PRTF staff once the request is received. PRTF staff may also call Clinical Care Manager once the request has been submitted.

A signature page signed by a Physician will serve as the Physician’s order. Request can be signed by a Primary Care Physician, the Physician who is discharging the Member from a higher level of care, the treating psychiatrist in an outpatient setting, or the treating Physician at the PRTF who evaluates the Member prior to admission.

Fax completed forms to:

BlueCare/TennCareSelect
1-800-292-5311

F. Transcranial Magnetic Stimulation

Transcranial Magnetic Stimulation (TMS) is an approved treatment for major depressive disorder for all BlueCross lines of business. TMS is not an approved treatment for other diagnoses or conditions.

TMS is a non-invasive method of delivering electrical stimulation to the brain. The therapy is administered in an inpatient, outpatient, or office setting. A treatment course may be repeated after a 3-month cessation period, if needed. All TMS services must be performed by a qualified and trained psychiatrist.

TMS is not allowed for pregnant women and for children under age 18.

TMS services provided in an outpatient setting must be authorized, and authorization requests must include a Physician’s order.

For services delivered from January 10, 2018, through June 30, 2018, retro-authorization requests may be submitted using process for specific lines of BlueCross business.

The following CPT® codes are used for billing TMS services:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90867</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management</td>
</tr>
<tr>
<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session</td>
</tr>
<tr>
<td>90869</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management</td>
</tr>
</tbody>
</table>
Note: To help ensure treatment in the inpatient setting is billed properly, use revenue codes (RCs): 0510, 0513 and 0920 in conjunction with appropriate CPT codes when services are initiated in an inpatient setting. Note that charges for TMS filed by a facility during inpatient care are included in the inpatient reimbursement and are not paid separately.

G. Medication Assisted Treatment

In conjunction with a new Buprenorphine Medication Assisted Treatment Program Description that was developed collaboratively by the Managed Care Organizations and the Division of TennCare (located at https://www.tn.gov/tenncare/tenncare-s-opioid-strategy.html), BlueCare Tennessee has implemented a new coding and reimbursement structure for Buprenorphine Medication Assisted Treatment (BMAT) services. The new codes are not restricted to behavioral health prescribers and can be utilized by any in-network prescriber with the appropriate waiver to render BMAT services and who also agrees to the BMAT Amendment by Notification by completing, signing and returning the Data Verification Form for Recognition and Reimbursement as a Buprenorphine Medication Assisted Treatment Prescriber.

Below are the billing codes (with descriptions) to be utilized in lieu of Evaluation and Management codes for the delivery of outpatient BMAT services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Modifier</th>
<th>HCPCS Description</th>
<th>BMAT Specific Description</th>
<th>Mode of Reimbursement</th>
<th>Licensure/ Certification Considerations</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient BMAT – Induction/ Stabilization Phase</td>
<td>H0014</td>
<td>HG</td>
<td>Alcohol and/or drug services; ambulatory detoxification</td>
<td>Alcohol and/or drug services; ambulatory detoxification – Buprenorphine induction (approx. 60 minutes)</td>
<td>Alcohol and/or drug services; ambulatory detoxification – Buprenorphine induction (approx. 60 minutes)</td>
<td>Network Eligible Buprenorphine prescriber</td>
<td>This code includes prescriber and counseling services and is to be used in lieu of (not in addition to) Evaluation and Management codes during the Induction Phase of BMAT. Induction Phase generally includes 2-5 visits. Measures may be put in place to monitor for outliers. While there is no prior authorization required to bill using this code, there may be authorization requirements specific to Buprenorphine.</td>
</tr>
<tr>
<td>Outpatient BMAT – Maintenance Phase</td>
<td>H0016</td>
<td>HG</td>
<td>Alcohol and/or drug services; medical/somatic intervention in ambulatory setting</td>
<td>Buprenorphine services in ambulatory setting – includes therapy required by BMAT Program Description and being provided by mental health professional practicing within scope of licensure</td>
<td>One billable encounter per day, both services delivered same day</td>
<td>Network Eligible Buprenorphine prescriber and in-network mental health professional (if prescriber is not a psychiatrist/addictionologist). See BMAT Program Description for more information</td>
<td>This code is to be used in lieu of (not in addition to) Evaluation and Management codes and includes counseling/therapy services delivered on the same day, in the same office, by the prescriber or employee who is a mental health professional practicing within scope of licensure. While there is no prior authorization required to bill using this code, there may be authorization requirements specific to Buprenorphine.</td>
</tr>
</tbody>
</table>
### H. Access and Availability of Behavioral Health Services

BlueCare Tennessee will provide behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures issued by the Department of Mental Health and Substance Abuse Services (DMHSAS) and approved by the Division of TennCare. Providers are required to meet the following time frames for admissions and appointments for the following levels of care:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Geographical Access Requirement for the Service</th>
<th>Maximum Time for Admission/Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>Transport access &lt;90 miles travel distance and &lt;120 minutes travel time for all CHILD and ADULT Members</td>
<td>4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)</td>
</tr>
<tr>
<td>24-Hour Psychiatric Residential Treatment</td>
<td>Not subject to geographic access standards</td>
<td>Within 30 Calendar days</td>
</tr>
<tr>
<td>Outpatient Non-MD Services</td>
<td>Transport access &lt;30 miles travel distance and &lt;45 minutes travel time for at least 75% of CHILD and ADULT Members and &lt;60 miles travel distance and &lt;60 minutes travel time for all CHILD and ADULT Members.</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td>Service Type</td>
<td>Geographic Access Requirement for the Service</td>
<td>Maximum Time for Admission/Appointment</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Intensive Outpatient</strong>&lt;br&gt;(May include Day Treatment (adult), Intensive Day Treatment (Children &amp; Adolescent) or Partial Hospitalization)</td>
<td>Transport access &lt;90 miles travel distance and &lt;90 minutes travel time for 75% of CHILD and ADULT Members and &lt;120 miles travel distance and &lt;120 minutes travel time for all CHILD and ADULT Members.</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td><strong>Inpatient Facility Services</strong> (Substance Abuse)</td>
<td>Transport access &lt;90 miles travel distance and &lt;120 minutes travel time for all CHILD and ADULT Members.</td>
<td>Within 2 calendar days; for detoxification-within 4 hours in an emergency and 24 hours for non-emergency</td>
</tr>
<tr>
<td><strong>24 Hour Residential Treatment Services</strong> (Substance Abuse)</td>
<td>Not subject to geographic access standards.</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td><strong>Outpatient Treatment Services</strong> (Substance Abuse)</td>
<td>Transport access &lt;30 miles travel distance and &lt;30 minutes travel time for 75% of CHILD and ADULT Members and &lt;45 miles travel distance and &lt;45 minutes travel time for all CHILD and ADULT Members.</td>
<td>Within 10 business days; for detoxification-within 24 hours</td>
</tr>
<tr>
<td><strong>Intensive Community-Based Treatment Services</strong></td>
<td>Not subject to geographic access standards</td>
<td>Within 7 Calendar days</td>
</tr>
<tr>
<td><strong>Tennessee Health Link Services</strong></td>
<td>Not subject to geographic access standards</td>
<td>Within 30 Calendar days</td>
</tr>
<tr>
<td><strong>Psychosocial Rehabilitation</strong>: (may include Supported Employment, Illness Management &amp; Recovery, Peer Recovery Services, or Family Support service)</td>
<td>Not subject to geographic access standards</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td><strong>Supported Housing</strong></td>
<td>Not subject to geographic access standards</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td><strong>Crisis Services</strong> (Mobile)</td>
<td>Not subject to geographic access standards</td>
<td>Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations</td>
</tr>
<tr>
<td><strong>Crisis Stabilization</strong></td>
<td>Not subject to geographic access standards</td>
<td>Within 4 hours of referral</td>
</tr>
</tbody>
</table>
I. BlueCare Behavioral Health Quality Management

One of the primary goals of BlueCare Tennessee Behavioral Health Quality Management is to continually improve care and services. Through data collection, measurement, and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and for high-risk or special populations. Data collected are valid, reliable and comparable over time. BlueCare Tennessee takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring clinical quality indicators;
- Review and analyze data from indicators;
- Identify opportunities for improvement;
- Prioritize opportunities to improve processes or outcomes of behavioral healthcare delivery based on risk assessment, ability to impact performance, and resource availability;
- Identify the at-risk population within the total membership;
- Identify the measures to be used to assess performance;
- Collect valid data for each measure and calculate the baseline level of performance;
- Establish performance goals or desired level of improvement;
- Develop interventions that impact performance; and
- Analyze results to determine where performance is acceptable and, where it is not, identify barriers to improving performance.

1. Complaints and Quality of Care Concerns

One method of identifying opportunities for process improvement is to collect and analyze the content of Member complaints and other reported quality of care concerns. Behavioral Health Quality Management investigates all reported complaints and quality of care concerns. Data from these investigations are compiled, tracked, and reported to internal committees for analysis and determination of further action or resolution.

2. Reporting Adverse Occurrences to BlueCare Tennessee

Participating Providers are required to report all adverse events involving Members to BlueCare Tennessee. Providers must report adverse events to BlueCare Tennessee within twenty-four (24) hours. Adverse events are defined as occurrences that represent actual or potential serious harm to the well-being of Members or to others by a Member who is in behavioral health treatment. Report all adverse occurrences to BlueCare Tennessee using the Division of TennCare Adverse Occurrence Report (AOR) form found at http://bluecare.bcbst.com/forms/Provider%20Forms/provider-notification-AOR.pdf.

Examples of reportable adverse occurrences include, but are not limited to the following:

- Suicide death
- Non-suicide death that occurs in a residential, inpatient or crisis stabilization unit (CSU) treatment setting. Non-suicide deaths of Members receiving outpatient behavioral health treatment services should be reported only if there would be reasonable suspicion that the death was related to behavioral health treatment (e.g., overdose, potential medication error or reaction.)
- Homicide
- Homicide attempt with significant medical intervention*
- Suicide attempt with significant medical intervention*
- Allegation of abuse or neglect including peer-to-peer (physical, sexual, verbal)
- Medical emergency occurring in residential, inpatient or CSU treatment settings requiring significant medical intervention* (e.g., myocardial infarction, medically unstable Member.)
- Accidental injury with significant medical intervention*
• Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention*
• Treatment complications, including (medication errors and adverse medication reactions)
• Eloпement (специfiп to inпatient and рeзidential services only)
• Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting
• Other occurrences representing actual or potential serious harm to a Member not listed above

*Significant medical intervention: An event requiring medical intervention that cannot be provided in the behavioral health treatment facility (for example, a myocardial infarction requiring treatment in an emergency department or medical hospital).

BlueCare Tennessee may undertake an investigation based on the circumstances of each occurrence, or on any identified trend of adverse occurrences. As a result, Providers may be asked to furnish records, and/or to engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. BlueCare Tennessee Providers may also be subject to disciplinary action through BCBST Clinical Risk Management or the BCBST/BlueCare Credentialing Committee, or both.

3. Site Visits for Quality Reviews and Treatment Record Audits
BlueCare Tennessee, or its designee, conducts site visits at Provider facilities or offices to monitor compliance with regulatory and contractual standards. A site visit, scheduled or unscheduled, quality review may be conducted as part of monitoring an investigation stemming from a Member complaint, adverse occurrence, or other quality issue.

Treatment record audits to include each level of care are conducted at least annually or more frequently if deemed necessary. Providers will be notified prior to the scheduled audit and will be provided with a copy of the audit tool as well as a detailed Member list of charts that will be audited.

BlueCare Tennessee may conduct scheduled or unscheduled Quality Management site visits. Following the site visit, the Provider will receive feedback which may require an action plan demonstrating Providers comply with relevant standards in an effort to provide quality care and service to BlueCare Tennessee Members.

J. Provider Network Participation
Effective January 1, 2015, BlueCross BlueShield of Tennessee/BlueCare Tennessee manages the BlueCare behavioral health network of Providers, including Provider recruitment, credentialing, and contracting activities. (See Section XVI. Provider Networks in this Manual for network participation criteria.)

K. Billing Guidelines
Unless noted otherwise in this section, Providers should follow the billing guidelines outlined in Section V. Billing and Reimbursement in this Manual. The following tips may help avoid some common behavioral health claims filing issues:
• Diagnostic and Statistical Manual of Mental Disorders codes are used for authorization purposes; claims must be filed with correct ICD codes.
• Clinical and/or correct coding edits can be minimized by ensuring all encounters for the same date of service for the same Member are included on the claim.
• When the rendering Provider is a master's level (but not independently licensed) employee of a Mental Health Outpatient Facility, the NPI of the supervising professional must be reported when billing for the services performed by the non-licensed master's level individual. It is not appropriate
to list the Billing entity's NPI, as the rendering Provider, when the rendering Provider is a non-licensed master's level individual.

To further clarify this language, the rendering Provider (i.e., a master's level clinician who is not independently licensed) must be an employee of a facility that is licensed as a Mental Health Outpatient Facility by TDMHSAS. Additionally, the licensed Mental Health Outpatient Facility shall be contracted with BlueCare Tennessee, in a manner (specified by the Provider's agreement i.e., Contract), which allows the Provider to render behavioral health professional services by a non-licensed master's level individual and subsequently bill such services under the NPI of the supervising professional.

- Professional claims need a taxonomy code to be submitted for the billing and rendering NPIs. It is extremely important that both the billing and rendering Provider taxonomy codes match the taxonomy codes on file for BlueCare. If you don't submit the appropriate taxonomy codes for BlueCare, CoverKids, or BlueCare Plus, your claims may be denied or the reimbursement reduced.
- To receive appropriate reimbursement, BlueCare Behavioral Health Providers should bill the correct modifier code in accordance with their licensure levels. Appropriate modifiers are as follow:
  - None = MD Level
  - HP = Doctoral Level
  - HO = Masters Level
  - SA = Nurse Practitioner Rendering Service in Collaboration with a Physician
- Refer to Section V. Billing & Reimbursement in this Manual for interim billing guidelines (should a Member’s length of stay span more than one month).
- Refer to Section V. Billing & Reimbursement in this Manual for filing corrected bills.

### L. Contact Us

Providers can locate information, tools and resources on our company websites, [http://bluecare.bcbst.com](http://bluecare.bcbst.com) and [www.bcbst.com](http://www.bcbst.com). The websites offer access to information and practical recommendations related to addiction and recovery, behavioral health, medications, life events, and daily living skills.

To arrange behavioral health services for BlueCare Tennessee Members call the appropriate Provider Service line below Monday through Friday, 8 a.m. to 6 p.m. (ET):

- **BlueCare** 1-800-468-9736
- **TennCare Select** 1-800-711-4104

To request authorization for services, call BlueCare Tennessee Utilization Management.

- **BlueCare** 1-888-423-0131
- **TennCare Select** 1-800-711-4104

**Note**: Requests for urgent services (inpatient and detox) are received and processed telephonically 24-hours-a-day, 7-days-a-week.

**Note**: Requests for non-urgent services are reviewed Monday through Friday, 8 a.m. to 6 p.m. (ET) and can be requested via telephone, fax, or web. Fax and web services are available 24-hours-a-day, 7-days-a-week.

Primary Care Providers may also call our toll-free primary care provider consultation line, staffed by Board Certified Psychiatrists. Staff are available for telephone consultation on all aspects of mental and substance use disorder treatment, including medications. This service is available Monday through Friday, 9 a.m. to 5 p.m. (ET).
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Please call 1-800-367-3403 and identify yourself as a TennCare primary care Provider seeking psychiatric consultation services.

In the event of a crisis, BlueCare Tennessee Members and Providers can call the State of Tennessee crisis hotline or their local crisis team for assistance. (See Section I. Introduction in this Manual for a listing of behavioral health crisis contact numbers.) For urgent situations, Members will be referred to Providers in their community who can see them within forty-eight (48) hours.

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XVI. Provider Networks

Participation in BlueCross BlueShield of Tennessee/Volunteer State Health Plan, dba BlueCare Tennessee ("BCBST/BlueCare Tennessee") Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BCBST/BlueCare Tennessee Provider Networks, or needing to communicate any changes in their practice may call their local Provider Network Manager. (See Section I. Introduction, for specific contact numbers.)

A. Network Participation Criteria

BCBST/BlueCare Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in one of our Provider Networks. These Terms and Conditions will be consistently applied to all Providers regardless of participation status. These Terms and Conditions will apply to any Provider who:

- Is a Network Provider;
- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider’s participation;
- has a significant change in practice, or other intervening event or activity, which initiates a re-application and/or reconsideration of the Provider’s current participation status; or

B. Changes in Practice

Certain federal and state regulations may require BCBST/BlueCare Tennessee contracted Providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice:

- E-mail a completed Provider Change Form to (https://www.bcbst.com/providers/forms/Practitioner_Change_Form.pdf) and any attachments to us at PNS_GM@bcbst.com and

Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure Provider directories utilized by Members contain the most current and correct information about their practice.

The following may require reconsideration for continued participation of a currently contracted Provider, immediate termination of a contracted Provider, review of the initial application by a non-contracted Provider, or re-application for participation by a non-contracted Provider.

The following changes may require reconsideration and/or re-application for participation in a BCBST/BlueCare Tennessee Provider Network. BlueCross BlueShield of Tennessee and BlueCare Tennessee reserves the right to interpret and
apply these criteria in its sole discretion and judgment. Any Provider adversely affected by BCBST/BlueCare Tennessee’s application of these criteria will be entitled to the appropriate appeals procedure set forth in the Provider Dispute Resolution Procedure or set forth in this Manual.

Practitioner

Including but not limited to:
- Change in practice locations;
- Change in practice specialty;
- Change in ownership;
- Entering into or exiting from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice claim(s) and/or judgment(s);
- Indictment, arrest, conviction or moral turpitude allegation;
- Adverse or adversarial relationship with BCBST/BlueCare Tennessee;
- Any material change, which affects the Practitioner’s ability to perform its obligations to Members and/or BCBST/BlueCare Tennessee;
- Any material change in the information submitted on the pre-application or application.

Institutional or Ancillary Providers

Including but not limited to:
- Change in ownership;
- Malpractice claim(s) and/or judgment(s);
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all Providers to maintain a license.
- Adverse or adversarial relationship with BCBST/BlueCare Tennessee;
- Any material change which affects the organization’s ability to perform its obligations to Member(s) and/or BCBST/BlueCare Tennessee;
- Any material change in the information submitted on the pre-application or application.

C. Providers Denied Participation

Providers denied participation in a BCBST/BlueCare Tennessee Provider Network for other than network need, may not be considered for reapplication for a minimum of one (1) year from the date of denial. Providers will be given reason for denial as well as notice when they may reapply to networks as determined by and at the Provider Participation Standards Committee’s (PPSC) sole discretion.

This requirement may be waived by BCBST/BlueCare Tennessee in its sole discretion.
D. Removal of Providers from BCBST/BlueCare Tennessee Provider Network

Except as set forth in Section XI-Quality Improvement Program, the PPSC will review and take action on all requests for removal of Providers from BCBST/BlueCare Tennessee Provider Networks including, but not limited to, lack of minimum participation standards, no malpractice insurance, aberrant billing practice, pattern of out of network referrals, or Providers that have (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons set forth in the Provider’s Agreement. If the PPSC determines a Provider falls within any of these termination reasons, a Provider may be immediately terminated from the BCBST/BlueCare Tennessee Networks or BCBST/BlueCare Tennessee may refuse participation in any BCBST/BlueCare Tennessee Networks.

The PPSC may also address any contractual breach of contracts that can lead to terminating a network Provider. In either event, Provider shall not be considered, at the discretion of BCBST/BlueCare Tennessee, for network participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST/BlueCare Tennessee, unless the charges are dismissed or otherwise resolved in the Provider’s favor.

The PPSC has delegated the responsibility for initiating administrative terminations to the Provider Network Operations (PNO) Department. If the PNO staff confirms all BCBST/BlueCare Tennessee policies and procedures were followed related to such administrative terminations, notice of termination may be sent without committee review. If the PNO staff determines there are unique circumstances that warrant a committee level review, the termination action will be brought to PPSC. A list of the reasons for administrative termination of a provider’s participation include, without limitation:

- Loss of License
- Medicare/Medicaid or CHIP Sanctions
- Failure to submit all required information necessary to complete the BCBST/BlueCare Tennessee Credentialing or Recredentialing process
- Lack of Network Specific Admitting Privileges (or provision of coverage by a BCBST/BlueCare Tennessee participating Provider)
- Lack of Network Specific 24 Hour Coverage
- Retired/Deceased/Moved out of State
- Excluded from participation in the Medicare/Medicaid and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
- No Claims Activity Within 12 Consecutive Months (Provider NPI does not appear on claims in previous 12 months)
- Appearance on the CMS Preclusion List
- Termination of Medicaid ID/participation by TennCare

A report will be submitted to the PPSC reflecting administrative terminations at least quarterly. Providers that are removed from a BCBST Participating Network may
reapply in accordance with the Network Participation Criteria or the timeframe set forth in the Provider termination notice.

In those cases where a Provider is removed from all BCBST/BlueCare Tennessee Networks, credentials will be suspended the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

E. Provider Termination Appeal Process

Except as set forth in Section XI – Quality Improvement Program or Section XII(B) – Provider Dispute Resolution Procedure, Provider whose network participation has been terminated pursuant to the terms of their contract may be entitled to the procedural remedies set forth below.

All notices concerning Provider Network Management contract terminations with cause or without cause are communicated to the Provider according to the provisions in the Provider’s contract.

Termination notices sent to Providers will include instructions on appealing the termination decision.

Providers whose network participation has been terminated without cause may take any dispute concerning this termination to binding arbitration as set forth in Section E(1)(c) below.

Providers should consult the section on Reporting Corrective Actions (Section XI(D)(IV) concerning BCBST’s reporting obligations to regulatory agencies.

1. APPEAL OF WITH CAUSE TERMINATION OF A PARTICIPATING PROVIDER

   i. Reconsideration

   i. The Provider may request a reconsideration of BCBST’s decision by submitting a request in writing within thirty (30) days of the date of the notice of termination to the Provider. Failure to meet this requirement will result in a waiver of the right to appeal the termination. The PPSC will send to Provider a response to this request for reconsideration.

   b. Appeal

   i. If Provider is not satisfied with BCBST’s response to Provider’s reconsideration request, Provider may request an appeal by telephonic hearing. Provider must request in writing a telephonic hearing no later than fourteen (14) days after BCBST’s decision on Provider’s request for reconsideration. Failure to meet this requirement will result in a waiver of the right to a telephonic hearing.

   ii. Following receipt of a written request for a telephonic hearing from a Provider pursuant to section 1.b.i, BCBST will contact the Provider to establish a mutually acceptable date and time for the telephonic hearing, which generally shall be conducted within the thirty (30) day period following receipt of the written request. If the Provider fails to appear at the hearing without good cause, the right to schedule another hearing is forfeited.

   iii. For Practitioners, telephonic hearings shall be conducted by a panel chosen by BCBST.

   iv. For Institutional and Ancillary Providers, telephonic hearings shall be conducted by a hearing officer chosen by BCBST.
v. Formal rules of evidence or legal procedure will not be applicable during any telephonic hearing.

vi. In addition to any procedure adopted by the Panel/Hearing Officer for telephonic hearings:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.

2. The hearing may be recorded by a court reporter at BCBST’s discretion.

3. The Provider and BCBST must provide the other party with a list of witnesses expected to testify on their respective behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.

4. Each party has the right to inspect and request copies of any documentary information that the other party intends to present during the hearing, at the inspecting party’s expense, upon reasonable advance notice.

5. During the hearing, each party has the right to:

   a. Call witnesses

   b. Cross-examine opposing witnesses

6. Following the hearing, each party may obtain copies of any record of the hearing, upon payment of the charges for that record.

vii. The Panel/Hearing Officer will send BCBST and the Provider a written response within sixty (60) days of the date of the telephonic hearing. The Panel/Hearing Officer’s decision will be reviewed by the PPSC and BCBST’s final decision will be sent to the Provider.

   c. Binding Arbitration

      i. If the Provider is not satisfied with BCBST’s final decision, the next and final step is binding arbitration. The Provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XII(B) – Provider Dispute Resolution Procedure.

2. APPEAL OF DENIAL OF APPLICATION OF AN APPLICANT

   a. Written Appeal

      i. A Provider may appeal by submitting a written statement of his/her position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the PPSC. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

   b. Binding Arbitration

      i. If the Provider is still not satisfied with the PPSC’s decision, the next and final step is binding arbitration. The Provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XII(B) – Provider Dispute Resolution Procedure.

F. Participation in BlueCare and TennCare Select Networks

BlueCare Tennessee Provider Network Management participation criteria for 1) Practitioners; 2) Institutional Providers; and 3) Ancillary Providers in BlueCare Tennessee Provider Networks follow:
1. Minimum Practitioner Network Participation Criteria

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCare Tennessee and its affiliates will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Practitioner Network Attribute</th>
<th>HMO BlueCare/TennCareSelect</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] I. Tennessee &amp; Contiguous Counties</td>
<td>Required</td>
</tr>
<tr>
<td>[ ] II. State License</td>
<td></td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td>Required</td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed</td>
<td>Required</td>
</tr>
<tr>
<td>3. If the Provider’s medical license has been revoked, suspended or not renewed (a license &quot;revocation&quot;) by any jurisdiction, for cause, or the Provider has surrendered or agreed to surrender license to avoid such a revocation, Provider will be considered for participation at a minimum of one (1) year after the date that Provider’s license was reinstated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider maintains licensure.</td>
<td>Required</td>
</tr>
<tr>
<td>[ ] III. Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>[ ] IV. Accept Terms of Contract</td>
<td>Required</td>
</tr>
<tr>
<td>[ ] V. Board Certified/Eligible</td>
<td>Required</td>
</tr>
<tr>
<td>[ ] VI. Must be able to meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
</tr>
<tr>
<td>[ ] VII. Successful Site Evaluation</td>
<td>Required for Primary Care and High Volume Specialists</td>
</tr>
<tr>
<td>Factors reviewed at site visit are:</td>
<td></td>
</tr>
<tr>
<td>Accessibility/appearance, Risk Management Policies/Procedures, access/availability of medical services, medical records administration, valid certification for regulated services and personnel.</td>
<td></td>
</tr>
<tr>
<td>[ ] VIII. Admitting Privileges</td>
<td></td>
</tr>
<tr>
<td>Maintain admitting privileges (or provision for coverage by a BlueCare Tennessee participating Provider) with a BlueCare Tennessee network hospital*</td>
<td>Required</td>
</tr>
<tr>
<td>*Any exceptions must be approved by BlueCare Tennessee</td>
<td></td>
</tr>
<tr>
<td>[ ] IX. Availability Standards</td>
<td></td>
</tr>
<tr>
<td>Network participation is dependent on the business needs of BlueCare Tennessee and its affiliates</td>
<td></td>
</tr>
<tr>
<td>1. Primary Care</td>
<td>Limited Network. Must meet Network Availability Standards</td>
</tr>
<tr>
<td>2. Hospital Based</td>
<td>Affiliated with Participating Hospital</td>
</tr>
<tr>
<td>Anesthesiology (includes CRNAs)</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td>Pathology</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td>Radiology</td>
<td>Fee Schedule</td>
</tr>
<tr>
<td>Practitioner Network Attribute</td>
<td>HMO BlueCare/TennCareSelect</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Fee Schedule</td>
</tr>
<tr>
<td><strong>Hospital Required to Deliver</strong></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>3. Specialists</strong></td>
<td>Limited Network. Must meet Network Availability Standards</td>
</tr>
</tbody>
</table>

### X. Member Access Standards

1. Agrees to provide care to members within BlueCare Tennessee standards
   
2. Demonstrates a practice history, which BlueCare Tennessee deems consistent and comparable with Providers’ ability to comply with these standards.
   
2.1 Regular: Routine Examination, TennCare Kids, Preventive Care, Physical Exam ≤ 3 weeks

2.2 Prenatal Care:
   - First Trimester ≤ 3 weeks
   - Second Trimester < 15 days

2.3 Urgent Care (Adult & Child) ≤ 48 hours

2.4 Emergency Care (Adult & Child) Immediate

2.5 Specialty Care (Adult & Child) ≤ 3 weeks

2.6 Wait Times
   
1) Office Wait Time (including lab and x-ray) ≤ 45 minutes

2) Member Telephone Call (during office hours):
   - Urgent ≤ 15 minutes
   - Routine Same Day

3) Member Telephone Call (after office hours):
   - Urgent ≤ 30 minutes
   - Routine ≤ 90 minutes

2.7 7Day/24 Hour Coverage through Par Providers Required

### XI. Reimbursement

1. Agrees to the price and reimbursement schedule for the Network Required

2. Agrees to the reimbursement methodology Required

3. Agrees not to balance bill member Required

4. Delegation
   Subject to minimum criteria and approval by Delegated Oversight Committee

5. Administrative Services Only (ASO) Available No

6. Acceptance of Electronic Funds Transfer (EFT) Required

7. Electronic Claims Submission Required

### XII. Quality Improvement/Utilization Review/Medical Management Program

1. Cooperate with BlueCare Tennessee QI & UM Programs Required

2. Maintain a QI/UM Plan Required

3. Demonstrate practice style and history, which BlueCare Tennessee deems consistent and comparable with BlueCare Tennessee quality management program standards and practices. Required

4. Meet BlueCare Tennessee acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency. Required
<table>
<thead>
<tr>
<th>Practitioner Network Attribute</th>
<th>HMO BlueCare/TennCare Select</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>XIII. General Provisions</strong></td>
<td></td>
</tr>
<tr>
<td>1. Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td>Required/Negotiated</td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required/Includes Stark</td>
</tr>
<tr>
<td>5. Practice style which is consistent with current standards of medical delivery</td>
<td>Required</td>
</tr>
<tr>
<td>6. Prescribing pattern, which is consistent with BlueCare Tennessee’s quality management program</td>
<td>Required</td>
</tr>
<tr>
<td>7. If the Provider’s Drug Enforcement Administration Certificate, Controlled Dangerous Substances Certificate, or any schedules thereof have been revoked, suspended or not renewed (a “revocation”) by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation, Provider shall not be considered for participation at a minimum of one (1) year after the date that Provider was re-issued a certificate or schedule, except as otherwise provided by applicable laws. If such a certificate or schedule revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains certification or schedules.</td>
<td>Required</td>
</tr>
<tr>
<td>8. If the Provider has: (1) been indicted; (2) been convicted of a crime; (3) committed fraud; or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BlueCare Tennessee Networks or BlueCare Tennessee may refuse participation in any BlueCare Tennessee Networks. In either event, Provider will be considered, at the discretion of BlueCare Tennessee for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BlueCare Tennessee, unless the charges are dismissed or otherwise resolved in the Provider’s favor.</td>
<td>Required</td>
</tr>
<tr>
<td>9. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).</td>
<td>Required</td>
</tr>
<tr>
<td>10. Term of Contract</td>
<td>Annual; August 1 notice</td>
</tr>
<tr>
<td>11. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
</tr>
<tr>
<td>12. Exclusivity Allowed</td>
<td>Yes</td>
</tr>
<tr>
<td>13. Defined Service Area</td>
<td>Statewide</td>
</tr>
</tbody>
</table>
### Practitioner Network Attribute

**14. If Provider has established an adversarial relationship with BlueCare Tennessee, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BlueCare Tennessee’s agreements with that Provider, other Providers, members or other parties. Provider may not be considered for initial or continued participation in BlueCare Tennessee Networks. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BlueCare Tennessee; initiating legal or administrative actions against BlueCare Tennessee in bad faith; BlueCare Tennessee’s prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against Members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BlueCare Tennessee prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BlueCare Tennessee.**

**Required**

**15. Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process or failure to maintain hospital privileges at a network hospital, no claims activity in previous 12 months. For administrative terminations, Provider may reapply upon cure of the deficiency.**

**Required**

### Institutional Network Attribute

#### 2. Minimum Institutional Provider Network Participation Criteria

*Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers.*

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCare Tennessee and its affiliates will consider Provider for participation in one or more of its Networks at its sole discretion.

#### I. Tennessee & Contiguous Counties

<table>
<thead>
<tr>
<th>Institutional Network Attribute</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I.</strong></td>
<td></td>
</tr>
<tr>
<td>Tennessee &amp; Contiguous Counties</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### II. State License

<table>
<thead>
<tr>
<th>Institutional Network Attribute</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>II.</strong></td>
<td></td>
</tr>
<tr>
<td>License is Current and Valid.</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>License is Unrestricted as to services performed.</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Institutional Network Attribute</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. If the Provider’s license has been revoked, suspended or not renewed (a license “revocation”) by any jurisdiction, for cause, or if the Provider has surrendered license or agreed to surrender license to avoid such a revocation, the Provider will be considered for participation at a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
</tr>
</tbody>
</table>
### Institutional Network Attribute

<table>
<thead>
<tr>
<th>III.</th>
<th>Malpractice Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV.</td>
<td>Medicare Certification Requirements</td>
</tr>
<tr>
<td>V.</td>
<td>Accreditation Requirements</td>
</tr>
<tr>
<td>VI.</td>
<td>Accept Terms of Contract</td>
</tr>
<tr>
<td>VII.</td>
<td>Meet Credentialing and Recredentialing Requirements</td>
</tr>
<tr>
<td>VII.</td>
<td>Availability Standards</td>
</tr>
<tr>
<td>IX.</td>
<td>Member Access Standards</td>
</tr>
<tr>
<td>X.</td>
<td>Reimbursement</td>
</tr>
<tr>
<td>XI.</td>
<td>Quality Improvement/Utilization Review/Medical Management Program</td>
</tr>
<tr>
<td>XII.</td>
<td>General Provisions</td>
</tr>
</tbody>
</table>

#### HMO

<table>
<thead>
<tr>
<th>BlueCare/TennCare Select/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Limited Network. Must meet Network Availability Standards.</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Required</td>
</tr>
</tbody>
</table>

#### Availability Standards

Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates

1. Institutional Providers

#### Member Access Standards

1. Agrees to provide care to Members within BlueCare Tennessee standards.
2. Demonstrates a medical delivery history, which BlueCare Tennessee deems consistent and comparable with Providers’ ability to comply with these standards.
3. Service Area Definition
4. Hospitals that are contracted in out-of-state counties, which are contiguous to Tennessee, must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis

#### Reimbursement

1. Agrees to the price and reimbursement schedule for the Network
2. Agrees to the reimbursement methodology
3. Agrees not to balance bill member
4. Delegation
5. Administrative Services Only (ASO) Available
6. Acceptance of Electronic Funds Transfer (EFT)
7. Electronic Claims Submission

#### Quality Improvement/Utilization Review/Medical Management Program

1. Cooperate with BlueCare Tennessee QI & UM Programs
2. Maintain a QI/UM Plan
3. Demonstrate medical delivery style and history, which BlueCare Tennessee deems consistent and comparable with BlueCare Tennessee quality management program standards and practices.
4. Completion of Leaf Frog Survey

#### General Provisions

1. Meet Member satisfaction standards - Based on member complaints, grievances, and satisfaction survey

XVI-10
### Institutional Network Attribute

<table>
<thead>
<tr>
<th>Institutional Network Attribute</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td>Required/Negotiated</td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required/Includes Stark</td>
</tr>
<tr>
<td>5. Medical Delivery style which is consistent with current standards of medical delivery</td>
<td>Required</td>
</tr>
<tr>
<td>6. Claims filing method</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>7. If any person who has an ownership interest of the Provider has:</td>
<td>Required</td>
</tr>
<tr>
<td>(1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BlueCare Tennessee Networks or BlueCare Tennessee may refuse participation in any BlueCare Tennessee Networks. In either event provider will be considered, at the discretion of BlueCare Tennessee, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BlueCare Tennessee, unless the charges are dismissed or otherwise resolved in the Provider's favor.</td>
<td>Required</td>
</tr>
<tr>
<td>8. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).</td>
<td>Required</td>
</tr>
<tr>
<td>9. Term of Contract</td>
<td>See Exhibit B-1</td>
</tr>
<tr>
<td>10. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
</tr>
<tr>
<td>11. Exclusivity Allowed</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Defined Service Area</td>
<td>Statewide</td>
</tr>
<tr>
<td>13. Provider has not established an adversarial relationship with BlueCare Tennessee, Members or participating providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BlueCare Tennessee's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: creditable evidence of making defamatory statements about BlueCare Tennessee; initiating legal or administrative actions against BlueCare Tennessee in bad faith; BlueCare Tennessee's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to &quot;gag&quot; the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BlueCare Tennessee prior to receiving a final determination of that dispute in accordance with BlueCare Tennessee’s Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BlueCare Tennessee.</td>
<td>Required</td>
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<tr>
<td>14. Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process, no claims activity in previous 12 months. For administrative terminations, Provider may reapply upon cure of the deficiency.</td>
<td>Required</td>
</tr>
</tbody>
</table>

XVI-11
## Institutional Network Attribute

<table>
<thead>
<tr>
<th>State License Requirements</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Institutional Network Attribute</strong></td>
<td><strong>TN</strong>: Licensed as an Institutional Network Attribute&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td><strong>TN</strong>: Licensed as an Acute Care Facility&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td><strong>TN</strong>: Licensed as an Ambulatory Surgery Facility&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td><strong>TN</strong>: Licensed as a Birthing Center&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td><strong>TN</strong>: Licensed as a Dialysis Center&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td><strong>TN</strong>: Licensed as an Inpatient Rehabilitation Facility&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td><strong>TN</strong>: Does not license Outpatient Rehabilitation Facilities&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td><strong>TN</strong>: Licensed as a Skilled Nursing Facility&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>N/A</td>
</tr>
<tr>
<td>Mobile X-ray Labs</td>
<td>N/A</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td><strong>TN</strong>: Licensed as an Ambulatory Surgery Facility&lt;br&gt;&lt;br&gt;<strong>Contiguous</strong>: Licensed in accordance with that state's licensing laws</td>
</tr>
</tbody>
</table>

## Accreditation and/or Certification Requirements

<table>
<thead>
<tr>
<th>Acute Care Hospital</th>
<th>JC, AOA, CHAP or AAAHC and Medicare A or State Site Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>JC, AOA, AAAHC, or AAAASF and Medicare B</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>JC, AOA, CHAP, AAAHC or Medicare B</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>Medicare A</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>JC, CARF or AOA and Medicare A</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Medicare A or Mental Health License</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Medicare A</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>N/A</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>N/A</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>CARF or American Academy of Pain Management</td>
</tr>
</tbody>
</table>

## Term of Contract

<table>
<thead>
<tr>
<th>Acute Care Hospital</th>
<th>Annual; August 1 notice to term January 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Annual; August 1 notice to term January 1</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>N/A</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>N/A</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
</tr>
</tbody>
</table>
3. Minimum Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCare Tennessee and its affiliates will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Ancillary Network Attribute</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Service Area</td>
<td>Required</td>
</tr>
<tr>
<td>Tennessee &amp; Contiguous Counties</td>
<td></td>
</tr>
<tr>
<td>II. State License</td>
<td>Required, as applicable</td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td></td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed.</td>
<td></td>
</tr>
<tr>
<td>3. If the Provider’s license has been revoked or not renewed (a license “revocation”) by any jurisdiction, for cause, or surrendered to avoid such a revocation, Provider will be considered for participation a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
</tr>
<tr>
<td>III. Minimum Insurance Requirements</td>
<td>Required, as applicable</td>
</tr>
<tr>
<td>IV. Medicare Certification Requirements</td>
<td>Required, as applicable</td>
</tr>
<tr>
<td>V. Accreditation Requirements</td>
<td>Required, as applicable</td>
</tr>
<tr>
<td>VI. Accept Terms of Contract</td>
<td>Required</td>
</tr>
<tr>
<td>VII. Meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
</tr>
<tr>
<td>VIII. Availability Standards</td>
<td>Limited Network. Must meet Network Availability Standards.</td>
</tr>
<tr>
<td>1. Ancillary Providers</td>
<td></td>
</tr>
<tr>
<td>IX. Member Access Standards</td>
<td>Required</td>
</tr>
<tr>
<td>1. Agrees to provide care to members within BlueCare Tennessee standards</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates a medical delivery history, which BlueCare Tennessee deems consistent and comparable with Providers’ ability to comply with these standards.</td>
<td>Required</td>
</tr>
<tr>
<td>3. Service Area Definition</td>
<td>TN Approved Counties only</td>
</tr>
<tr>
<td>Ancillary Network Attribute</td>
<td>HMO</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>X. Reimbursement</td>
<td>BlueCare/TennCareSelect/CHOICES</td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
</tr>
<tr>
<td>2. Agrees to the reimbursement methodology</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agrees not to balance bill member</td>
<td>Required</td>
</tr>
<tr>
<td>4. Delegation</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
</tr>
<tr>
<td>5. Administrative Services Only (ASO) Available</td>
<td>No</td>
</tr>
<tr>
<td>6. Acceptance of Electronic Funds Transfer (EFT)</td>
<td>Required</td>
</tr>
<tr>
<td>7. Electronic Claims Submission</td>
<td>Required</td>
</tr>
<tr>
<td>XI. Quality Improvement/Utilization Review/Medical Management Program</td>
<td></td>
</tr>
<tr>
<td>1. Cooperate with BlueCare Tennessee QI &amp; UM Programs</td>
<td>Required</td>
</tr>
<tr>
<td>2. Maintain a QI/UM Plan</td>
<td>Required</td>
</tr>
<tr>
<td>3. Demonstrate medical delivery style and history, which BlueCare Tennessee deems consistent and comparable with BlueCare Tennessee quality management program standards and practices.</td>
<td>Required</td>
</tr>
<tr>
<td>4. Agrees to Rapid Response Requirement</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>XII. General Provisions</td>
<td></td>
</tr>
<tr>
<td>1. Meet Member satisfaction standards - Based on member complaints, grievances, and satisfaction survey</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td>Required/Negotiated</td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required/Includes Stark</td>
</tr>
<tr>
<td>5. Medical Delivery style which is consistent with current standards of medical delivery</td>
<td>Required</td>
</tr>
<tr>
<td>6. Claims filing method</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>7. Must provide all services</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>8. Services must be available in all counties of a CSA (subcontracting permitted)</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>9. CLIA Certificate</td>
<td>Required for Independent Labs only</td>
</tr>
<tr>
<td>10. Valid contract with Magellan®</td>
<td>Required for Home Infusion only</td>
</tr>
<tr>
<td>11. If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BlueCare Tennessee Networks or BlueCare Tennessee may refuse participation in any BlueCare Tennessee Networks. In either event provider will be considered, at the discretion of BlueCare Tennessee, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BlueCare Tennessee, unless the charges are dismissed or otherwise resolved in the Provider’s favor.</td>
<td>Required</td>
</tr>
<tr>
<td>Ancillary Network Attribute</td>
<td>HMO BlueCare/TennCare Select/CHOICES</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>12. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s).</td>
<td>Required</td>
</tr>
<tr>
<td>13. Term of Contract</td>
<td>(See Exhibit B-1)</td>
</tr>
<tr>
<td>14. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
</tr>
<tr>
<td>15. Exclusivity Allowed</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Defined Service Area</td>
<td>Statewide</td>
</tr>
<tr>
<td>17. Provider has not established an adversarial relationship with BlueCare Tennessee, Members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BlueCare Tennessee’s agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: creditable evidence of making defamatory statements about BlueCare Tennessee; initiating legal or administrative actions against BlueCare Tennessee in bad faith; BlueCare Tennessee’s prior or pending termination of the Provider’s participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient’s medical condition, treatment or coverage (i.e. to “gag” the Provider from discussing relevant matters with Members). Involving Members or third parties in disputes with BlueCare Tennessee prior to receiving a final determination of that dispute in accordance with BCBST’s Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BlueCare Tennessee.</td>
<td>Required</td>
</tr>
<tr>
<td>18. Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process, no claims activity in previous 12 months. For administrative terminations, Provider may reapply upon cure of the deficiency.</td>
<td>Required</td>
</tr>
</tbody>
</table>
### Minimum Ancillary Provider Network Participation Criteria - Exhibit B-1

#### Ancillary Network Attribute

<table>
<thead>
<tr>
<th>Ancillary Network Attribute</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
</table>

#### State License Requirements

<table>
<thead>
<tr>
<th>Home Health</th>
<th>TN: Licensed as a Home Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Infusion Therapy</th>
<th>TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable Medical Equipment</th>
<th>TN: Licensed as a Durable Medical Equipment Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prosthetic/Orthotic Durable Medical Equipment Suppliers</th>
<th>TN: Does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</th>
<th>TN: Does not license Specialty Durable Medical Equipment Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only; e.g. ostomy supplies)</th>
<th>TN: Does not license Medical Supply Durable Medical Equipment Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice</th>
<th>TN: Licensed as a Hospice Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Independent Laboratory</th>
<th>TN: Licensed as a Medical Laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

#### Minimum Insurance Requirements

<table>
<thead>
<tr>
<th>Minimum Insurance Requirements</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Comprehensive Insurance (DME Only)</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Product Liability (Breast Prosthesis Only)</td>
<td>$500,000</td>
</tr>
</tbody>
</table>

#### Medicare Certification Requirements

<table>
<thead>
<tr>
<th>Medicare Certification Requirements</th>
<th>Medicare Part A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Hospice</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>Medicare Part B</td>
</tr>
</tbody>
</table>
## Minimum Ancillary Provider Network Participation - Exhibit B-1 (Cont’d)

<table>
<thead>
<tr>
<th>Ancillary Network Attribute</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accreditation Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment (Soft good supplies only, e.g., ostomy supplies)</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Agrees to Rapid Response Requirement</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Yes</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Yes</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
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</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Claims Filing Method</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment (Soft good supplies only, e.g., ostomy supplies)</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Hospice</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>CMS-1500</td>
</tr>
<tr>
<td><strong>Must Provide all Services</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>Required</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Required</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Required</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
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</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Minimum Ancillary Network Participation-Exhibit B-1 (Cont’d)

<table>
<thead>
<tr>
<th>Ancillary Network Attribute</th>
<th>HMO BlueCare/TennCareSelect/CHOICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services must be available in all counties of a CSA</strong> <em>(subcontracting permitted)</em></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>Required</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Required</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Required</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>Required</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
<td>Required</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment <em>(Soft good supplies only, e.g., ostomy supplies)</em></td>
<td>Required</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| **Term of Contract**                                                                         |                                      |
| Home Health                                                                                 | August 1 notice to term January 1    |
| Home Infusion Therapy                                                                        | August 1 notice to term January 1    |
| Durable Medical Equipment                                                                    | August 1 notice to term January 1    |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers                                      | August 1 notice to term January 1    |
| Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)* | August 1 notice to term January 1    |
| Medical Supply Durable Medical Equipment *(Soft good supplies only, e.g., ostomy supplies)* | August 1 notice to term January 1    |
| Hospice                                                                                    | August 1 notice to term January 1    |
| Independent Laboratory                                                                       | August 1 notice to term January 1    |

### G. Provider Identification Number Process

Before submitting claims to BlueCare Tennessee, a Provider must request and be assigned an individual provider identification number or contact us to register their National Provider Identifier (NPI). The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs), and 1099 forms. The assigned provider number or NPI in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee/BlueCare Tennessee networks.

Inquiries regarding the need for a new provider number or to register their NPI should be directed to:

- BlueCare Tennessee Provider Service line, 1-800-468-9736, and say “Contracts” when prompted.
H. Provider Rights and Responsibilities

BlueCare Network Providers have a right to:

- Receive information about the managed care organization, its services, and its Members’ rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy.
- Require that Members follow the plans and instructions for care that they have agreed upon with their Providers.
- Be involved in the adoption of clinical practice guidelines.
- Discontinue treatment of a Member with whom the Provider feels he/she cannot establish or maintain a professional relationship in accordance with the Contractor Risk Agreement.
- Specify the functions and/or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional/technical practice.
- Be paid upon receipt of a clean claim properly submitted by the Provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.g. of the Contractor Risk Agreement.

BlueCare Network Providers have the responsibility to:

- Recognize and abide by all applicable state and federal laws, regulations, and guidelines.
- Provide TennCare U.S. Department of Health and Human Services, and Office of Inspector General Controller evaluation through inspection, whether announced or unannounced, or other means any records pertinent to the Contractor Risk Agreement, including quality, appropriateness and timeliness of services, and such evaluation, when performed, shall be performed with the cooperation of the Provider.
- Assist in such reviews including the provision of complete copies of medical records.
- Provide Members and their representatives with access to their medical records.
- Treat Member with respect and recognition of their dignity and right to privacy.
- Allow Member participation in decision-making regarding their healthcare.
- Discuss Medically Appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Provide, to the extent possible, information that the managed care organization needs in order to provide quality care and service to Members.
- Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.
Serve as a conduit to the Practitioner community regarding the dissemination of quality and other health care information.

Abide by the accessibility and availability standards as set forth in the Physician Contract or Agreement.

Provide Covered Services on 24-hour-a-day, 7-days-a-week basis with call coverage through Network BlueCare Practitioners.

Be capable of providing comprehensive health care services, in accordance with the TennCare Program criteria for time/distance/patient volume, to their BlueCare Members. Comprehensive services shall include, but not be limited to:

* Preventive health services;
* Primary care services;
* Home health care services;
* Practitioner services; and
* Hospital services, including emergency services.

Provide Medically Necessary or covered preventive services regardless of the Member’s failure to pay applicable copayments and/or special fees.

Be responsible for supervising or coordinating the provision of initial and primary care to Members; for initiating specialty care; and for monitoring the continuity of Member care services.

In the event that TennCare deems an MCO unable to timely process and reimburse claims and requires the MCO to submit Provider claims for reimbursement to an alternate claims processor to ensure timely reimbursement, the Provider shall agree to accept reimbursement at the MCO’s contracted reimbursement rate or the rate established by TennCare, whichever is greater.
XVII. CREDENTIALING

A. Introduction

The BlueCross BlueShield of Tennessee (“BCBST”)/BlueCare Tennessee (“BCT”) Credentialing Program was established August 1, 1995. The Credentialing Program is designed around goals that reflect the BCBST/BlueCare Tennessee mission, as well as regulatory and accrediting requirements.

In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BCT developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BCT partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST/BCT Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BCT conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation.

Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BCT networks. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credentialing Activities

The Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee shall conduct peer review of those cases meeting the Exception Criteria of the Credentialing and Recredentialing of Practitioners policy (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, allow credentialing or continued credentialing of certain Practitioners who fall within the exception criteria and deny credentialing or terminate credentials of other Practitioners who also fall within the exception criteria. It shall be within the Committee’s discretion to assess and evaluate the facts of each individual case and determine whether it is in the best interest of BCT Members and BCT for a Practitioner to be credentialed or credentialing continued. In its discretion, the Committee may deny all Practitioners who fall within a certain exception criteria if the Committee determines that the health and welfare of BCT Members could be jeopardized by credentialing such Practitioners or continuing their credentialing. (Credentialing Committee Discretion Policy).

Practitioners or Organizational Providers have the right to review information (received from outside sources excluding peer review protected information) submitted with their application; correct erroneous information within thirty (30) days of receipt of completed application by contacting us at the address, phone number and/or email address listed below; or be informed of the status of their credentialing/recredentialing application upon request. Inquiries regarding the Credentialing process and/or Credentialing applications should be addressed to the following:
B. Credentialing Application

Credentialing applications are used to uniformly identify and gather specific information for all Practitioners and Organizational Providers that wish to participate with BCBST/ BCT. The BCBST/ BCT Credentialing standards apply to all licensed independent Practitioners or Practitioner groups who have an independent relationship with BCBST/ BCT. The BCBST/ BCT Credentialing Program determines whether Practitioners and other Health Care Professionals, licensed by the State and under contract to BCBST/ BCT, are qualified to perform their services and meet the minimum requirements defined by National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and the TennCare Risk Agreement. Verification of all required credentials is imperative.

Once Practitioners and Organizational Providers have completed the credentialing process, they will receive written notification within ten (10) days from BCBST/BCT’s Credentialing Department. Note: This notification does not guarantee acceptance in BCBST/ BCT networks; Practitioners and Organizational Providers are not considered participating in BCBST/BCT networks until they receive an acceptance letter from BCBST/ BCT’s Contracting Department. Our goal is to complete credentialing and contracting a Provider within thirty (30 days) of receiving a completed application.

CAQH APPLICATIONS SHOULD REFLECT THE FOLLOWING, ALONG WITH THEIR STANDARD REQUIREMENTS TO BE CONSIDERED COMPLETE:

- Detailed Explanation of any malpractice suit within the last five (5) years (NPDB reports or self-reported)
- Detailed Explanation of any question(s) answered, “Yes” on the application
- Letter of agreement signed by admitting Physician when Practitioner does not have current Hospital Privileges (If applicable)
- Copy of Certificate from Nationally Recognized Accrediting Body -- NP & PA (ANCC, AANP, if applicable)
- Ownership and Disclosure of Interest Statement
- Group Grid
- Other Supporting Documentation sent to Provider from BCT

Letter for NPs and PAs must include:

- The name and address of supervisory Physician;
- Verification the Physician is responsible for the care and treatment rendered;
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice;
- Verification that protocol exists and is located at the premises where the NP practices as required by state law; and
- APN License (NP only).
Electronic Funds Transfer (EFT)
- Providers are required to enroll in the EFT process. For enrollment information, Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.
- If you completed the Electronic Funds Transfer Information under Section V—Payment Information of the Credentialing Application, please include a VOIED check with the appropriate account number when returning your application.

The applying Provider will receive notification from BlueCare Tennessee when all documents have been received and the review process has begun. If all necessary documentation is not received within thirty (30) days of the documentation request date, the application will be closed as incomplete. The Provider has the right to correct erroneous information within thirty (30) days of receipt as well as check the status of application at any time during the credentialing/recredentialing process.

If you have any questions or need assistance, contact Provider Service line at 1-800-924-7141 and say “Credentialing and Contracting” when prompted.

C. Credentialing Policies

BlueCross BlueShield of Tennessee/BlueCare Tennessee has written policies and procedures for both the initial and re-credentialing process of Practitioners and Organizational Providers. The following policies are subject to change and should only be referenced as a guideline. Final determination of credentialing status is a decision of the BCBST/BCT Credentialing Committee. For specific assistance, or you need a copy of the actual policy, please contact your Provider Relations Consultant (see Section I for specific telephone numbers) or call the BCBST/BCT Credentialing Department at 1-800-357-0395.

**Note:** Primary Care Practitioner and OB/GYN office site visits are performed by BCBST/BCT Tennessee within six (6) months of the credentialing event.

1. Credentialing Process for Practitioner:
   The following information is required and/or must be verified for Practitioners:
   - A current, valid, full, unrestricted license to practice in the state of jurisdiction.
   - History of, or current license probation will be subject to peer review.
   - Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State Law) within the scope of the Practitioner’s practice, if applicable.
   - Work history for the last five years with documented gaps in employment over 90 days.
   - Malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (exceptions made for State Employees).
   - Clinical privileges in good standing at a licensed facility designated by the Practitioner as the primary admitting facility. (Any exceptions to this will be determined by the BCBST/BCT Credentialing Committee).
   - National Practitioner Data Bank (NPDB) report or Claims History Report from all malpractice carriers for the last five (5) years.
   - Board certification verification if the Practitioner indicates certified on application.
   - BCBST/BCT recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
   - Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).
   - Verification of a current, valid, unrestricted state license is sufficient for a Practitioner’s degree. Verification of board certification or highest level of education is necessary for specialty designation.

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- History of, or criminal conviction or indictment will be subject to peer review.
- Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BCBST/BCT credentialed Practitioner.
- Statement from applicant regarding:
  * Current or past physical or mental problems that may affect ability to provide health care;
  * Current or past substance use disorder;
  * History of loss of license and or felony convictions;
  * History of loss or limitation of privileges or disciplinary activity; and
  * An attestation to correctness/completeness of the application.
- Office site visit to each potential Primary Care Practitioner’s and OB/GYN’s office including documentation of a structured review of the site and medical record maintenance process. (See Credentialing XVII.D Practice Site Evaluations/Medical Record Practices.)
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP/PA as specified in the Rules and Regulations for the State in which they practice;
- Verification that Protocol exists and is located at the premises where NP/PA practices as required by state law.

Specific requirements for specialties listed:

- **Acupuncturist:**
  - Licensed as an Acupuncturist.
  - Proof of current diplomate status in acupuncture from NCCAOM and proof of completion of a 3-year post-secondary acupuncture training program or college acupuncture program that is ACAOM accredited.
  - DEA certificate not required.
  - No call coverage required.
  - No hospital privileges required.

- **Audiologist/Speech Therapist/Physical Therapist/Occupational Therapist:**
  - Current Licensure in State of Tennessee in Specialty will verify education.
  - If not practicing in Tennessee, education may be verified by certificate from:
    * American Occupational Therapy Certification Board;
    * American Speech-Language-Hearing Association;
    * Physical Therapist Certificate of Fitness, if applicable; or
    * Verification of highest level of education in specialty requested.
  - No call coverage required.
  - Clinical privileges not required.
  - DEA certificate not required.

- **Chiropractor:**
  - Clinical privileges not required.
  - DEA certificate not required.

- **CRNA:**
  - If credentialing is required, call coverage and hospital privileges are required.

- **Dentist:**
  - Minimum and exception criteria apply with the exception of:
    * Clinical privileges not required
    * General Dentists only require schedule 2 & 3 on their DEA
    * Call coverage not required

- **Dietitian/Nutritionist:**
  - Minimum and exception criteria apply with the exception of:
    * Licensed as a Dietitian/Nutritionist.
    * Minimum of a BA degree from an accredited U.S. college or university, with course approved by the American Dietetic Association’s Commission for a Didactic Program in Dietetics.

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• Must undergo a 6- to 12-month practice program or internship at a healthcare facility, community agency, or food service corporation, or do the equivalent in combination with their undergraduate course work.
• Completion of a Commission on Accreditation of Dietetics Education (CADE) accredited Didactic Program in Dietetics and pass the national board examination administered by the Commission on Dietetic Registration (CDR).
• Clinical privileges not required.
• Call coverage not required.
• DEA certificate not required.

**Genetic Counselor**
Minimum and exception criteria with the exception of:
• Licensed as a Genetic Counselor.
• Clinical privileges not required.
• Call coverage not required.
• DEA certificate not required.
• Certificate from National Society of Genetic Counselors (NSGC).
• Education must be from one of the 30 accredited universities that offer Genetic Counseling.

**Health Department Practitioners**
Minimum and exception criteria apply.

**Hospital Based (if practicing outside the hospital setting):**
• Must be credentialed and all Minimum and Exception Criteria applies.
• Any hospital-based Practitioner with additional practice sites are then evaluated and credentialed to that site’s highest standard according to the type of practice (i.e., Primary Care).

**Lactation Specialist**
• Minimum and exception criteria apply with the exception of:
• Licensed as a Registered Nurse at a minimum.
• Certification with IBCLC: Global Certification for Lactation Consultant.
• Clinical privileges not required.
• Call coverage not required.
• DEA certificate not required.

**Neuropsychologist (Ph.D):**
Minimum and Exception criteria apply in addition to:
• Clinical privileges not required.
• License must specify “Health Services Provider”.
• Ph. D. degree required.

**Nurse Practitioners or Nurse Mid-Wife:**
Minimum and Exception criteria apply in addition to:
• RN License.
• Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority for contiguous states.
• Certificate of Fitness required for Nurse Practitioners (NP), if applicable.
• If Prescriptive Authority includes a DEA certificate, all schedules must be verified.
• Certification most applicable to the nurse specialty from one of the following bodies:
  * American Nurses Credentialing Center;
  * American Academy of Nurse Practitioners;
  * American College of Nurse-Midwives Certification Council;
  * National Certification Corporation of Obstetric and Neonatal Nursing Specialties; or
  * National Certification Board of Pediatric Nurse Practitioners and Nurses.
• Written statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid oversight specialty who supervises the health care professional. Such statement must include:
  • The name and address of the supervising Practitioner;
• Verification the Practitioner is responsible for the care and treatment rendered by the NP;
• Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice;
• Verification that a Protocol exists and is located at the premises where the NP practices as required by state law.
• If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

Exclusion:
• Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility);
• DEA certificate not required, however, if applicant has DEA certificate it must be verified.

Optometrist:
Minimum and Exception criteria apply in addition to:
• State license must contain Therapeutic Certification.
• Hospital privileges are not required.
• DEA certificate not required, however, if applicant has DEA certificate it must be verified.

Pathologist
If credentialing is required, call coverage and hospital privileges are required.

Physical Therapist/Occupational Therapist
Minimum and Exception criteria apply in addition to:
• Current Licensure in State of Tennessee in Specialty will verify education. If not practicing in Tennessee, education may be verified by certificate from: American Occupational Therapy Certification Board, Physician Therapist Certificate of Fitness, if applicable or Verification of highest level of education in specialty requested.
• Exclusions:
  * No call coverage required
  * Clinical privileges not required
  * DEA certificate not required, however, if application has DEA certificate, all schedules must be verified.

Physician Assistant:
Minimum and Exception criteria apply in addition to:
• Certificate from the National Commission on Certification of Physician Assistants (NCCPA), if applicable.
• Written Statement from the BlueCross BlueShield of Tennessee credentialed Physician that has a valid PCP specialty who supervises the health care professional. Such statement shall include:
  * The name and address of the supervising Physician;
  * Verification that the Physician is responsible for the care and treatment rendered by Physician Assistant (PA);
  * Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the PA as specified in the Rules and Regulations for the State in which they practice;
  * Verification that a Protocol exists and is located at the premises where the PA practices as required by state law.
  * If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

Exclusion:
• Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
• DEA certificate not required, however, if applicant has DEA certificate, all schedules must be verified.
Pharmacist - Clinical
BCBST/BCT staff Pharmacists (and PBM Management)
Minimum and Exception criteria apply in addition to:
• Collaborative agreement between Pharmacy and Physician.
Exclusion:
• Clinical privileges not required.
• Call coverage not required.

Pharmacist – Disease Management
BCBST/BCT staff Pharmacists (and PBM Management)
Minimum and Exception criteria apply in addition to:
Copy of certificate for successful completion of accredited disease management program(s), if applicable

Pharmacist – Immunizing
BCBST/BCT staff Pharmacists (and PBM Management)
Minimum and Exception criteria apply in addition to:
• Certification of accredited immunizing program.
Exclusion:
• Clinical privileges not required
• Call coverage not required

Podiatrist
Minimum and Exception criteria apply in addition to:
• Clinical privileges not required (unless current privileges are indicated, they will be verified).

Radiologist
If credentialing is required, call coverage and hospital privileges are required.

Sleep Medicine
This specialty is designated only for Medical Doctors and Doctors of Osteopathy.

Speech Language Pathologist
Minimum and Exception criteria apply in addition to:
• Certificate of Clinical Competence – Speech Language Pathology (CCC-SLP) from American Speech-Language-Hearing Association (ASHA) – Not Required. However, if applicant has ASHA Certificate, it must be verified. If certificate has expired, certificate must be verified by previous certificate verification.

Urgent Care Physician
Minimum and Exception criteria apply (unless acting as PCP) with exception of:
• Clinical privileges.
• Call Coverage.
• Site Visit.

2. Credentialing Process for Behavioral Health Practitioners/Providers
The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

• Current, valid, unrestricted state license within the scope of the Practitioner’s practice.
• Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law.) within the scope of the Practitioner’s practice, if applicable.
• Work history for last five (5) years for initial credentialing; Last three (3) years’ work history for recredentialing. Explanation for all lapses of employment exceeding ninety (90) days.
• Proof of malpractice coverage in amounts of not less than $1,000,000 per case and $3,000,000 aggregate.
• National Practitioner Data Bank or Claims History Report from all malpractice carriers for the last five (5) years.
Clinical privileges in good standing at a facility designated by the Practitioner as the primary admitting facility. If Practitioner does not have clinical privileges, Practitioner must have a coverage arrangement with a BCT credentialed Practitioner/Provider, if applicable to scope of practice.

- Twenty-four (24)-hours-a-day, seven (7)-days-a-week call coverage
- Completed Education or Board certification in all practice specialties.

Specific requirements for specialties listed:

**Psychiatrist**
Minimum and exception criteria

**Addictionologist (non-Psychiatrist)**
Minimum and Exception criteria apply in addition to:
- Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.

**Addictionologist (Buprenorphine – Based Therapy for medication assisted treatment of substance abuse)**
Minimum and Exception criteria apply in addition to:
- DEA certificate with additional buprenorphine endorsement.
- Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.
- Certified in buprenorphine therapy in the state where practice is to occur.

**Psychologist or Psychoanalyst**
Minimum and Exception criteria apply in addition to:
- DEA certificate not required, verify if applicable.
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university and meet one of the following:
  1. Doctorate degree received from a college or university program on the American Psychological Association (APA) accredited list of counseling psychology or clinical psychology programs, or
  2. Completion of a pre-doctoral APA approved clinical internship at the time of graduation, or
  3. Listed in the National Register of Health Services Providers in Psychology, or
  4. Diplomate of the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

**Licensed Clinical Social Worker (LCSW)**
Minimum and Exception criteria apply in addition to:
- Master’s degree or higher from a graduate school or social work accredited by the Council on Social Work Education (CSWE).

**Professional Counselors/ Mental Health Counselors/ Licensed Substance Use Disorder Treatment Professionals**
Minimum and Exception criteria apply in addition to:
- Master’s degree or higher in mental health discipline.
- State licensed or certified at the highest level of independent practice in the state where practice is to occur.
- In states without licensure or certification, provider applicant must be a Certified Clinical Mental Health Counselor (CCMH) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) OR meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).
Marriage & Family Therapist
Minimum and Exception criteria apply in addition to:
- Master’s degree or higher in a mental health discipline.
- State licensed or certified at the highest level of independent practice in the state where practice is to occur, OR certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT) OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

Pastoral Counselors
Minimum and Exception criteria apply in addition to:
- Master’s degree or higher in mental health discipline.
- Must be licensed as a pastoral counselor and have certificate by the American Association of Pastoral Counselors.

Licensed Senior Psychological Examiner (SPE)
Minimum and Exception criteria apply in addition to:
- Master’s degree in Mental Health Counseling.

Employee Assistance Professional (EAP) Counselor
Minimum and Exception criteria apply in addition to:
- Certified as a Certified Employee Assistance Professional (CEAP).

Assistant Behavior Analyst (ABA)
Minimum and Exception criteria apply in addition to:
- Certified as an Assistant Behavior Analyst (BCaBA) by the Behavioral Analyst Certification Board.
- Minimum of a Bachelor’s degree from an accredited university
  * **Note:** Additional TennCare requirements; and
  * Degree must be for a BACB approved institution of higher education having the BACB required coursework and practice experience.

Certified Behavior Analyst (CBA)
Minimum and Exception criteria apply in addition to:
- Certified as Board Certified Behavior Analyst-Doctoral (BCBA D) by Behavior Analyst Certification Board (BCBA).
  * **Note:** Acceptable TennCare equivalents:
    - Currently licensed in the State of Tennessee for the independent practice of psychology, or
    - Currently a Qualified Mental Health Professional licensed in the State of Tennessee with the scope of practice to include behavior analysis; and
    Credential verification by the Managed Care Organization.
- Master’s or Doctorate degree from an accredited university that must be conferred in behavior analysis, education or psychology or in a degree program in which the candidate completed a (BACB) approved course sequence.
- Certified by Behavior Analyst Certification Board (BCBA).

The following information is required and/or must be verified for Behavioral Health Organizational Providers:
- Licensed in the state of TN.
- Professional liability coverage of $1,000,000 per case/$3,000,000 aggregate.
- Malpractice claims history for past five (5) years. NPDB reports or self-reported.
- Accreditation by: The Joint Commission, CARF, Council of Accreditation (COA), AOA, HFAP, AAAHC, (DNV GL), CHAP. If not accredited, a site visit review or copy of state site visit.
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- Certification from Medicare, Medicaid, TRICARE or state agencies if applicable.
- DEA certificate, if applicable.
- Staff roster for outpatient mental health and/or substance use disorder clinics.

**Inpatient Detoxification/Inpatient Substance Abuse Disorder Rehabilitation**

Minimum criteria with the exception of:
- Must have 24 hours/7-days-week skilled nursing staff.
- Oversight from a Medical Director.
- Must have an Addictionologist on staff or contracted or Medical Director must have three (3) years’ experience treating patients with substance use disorder.

**Inpatient Psychiatric/ Residential Psychiatric or Substance Abuse Disorder**

Minimum criteria with the exception of:
- 24 hour/7-days-a-week skilled nursing staff.
- Oversight from a Medical Director.

**Crisis Stabilization Unit**

Minimum criteria with the exception of:
- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by AOA, TRICARE, CARF or COA.
- Formal written agreement with TJC accredited provider for emergency psychiatric, substance use disorder, or medical care if not available on site.

**Partial Hospitalization (Psychiatric or Substance Abuse Disorder)**

Minimum criteria with the exception of:
- Must operate 3-5 days per week and at least 4-6 hours per day.
- Oversight from a Medical Director or licensed Program Director.
- Must be under the supervision of a Physician.

**Intensive Outpatient (Psychiatric or Substance Abuse Disorder)**

Minimum criteria with the exception of:
- Must have the supervision of a licensed clinician.
- Must provide services at least three (3) hours per day, 2-4 days per week.

**Outpatient Mental Health and/or Substance Abuse Disorder Clinic**

Minimum criteria with the exception of:
- Must have a governing body and an organized professional staff.
- Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters- or doctoral- level mental health clinician.
- Must have written credentialing criteria for all clinical staff.
- All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
- Must receive oversight from a licensed behavioral health professional.

**Crisis Stabilization Unit**

Minimum criteria with the exception of:
- Program must be part of a Joint Commission accredited hospital or health care organization that provides psychiatric services or Program is part of a facility accredited by AOA, TRICARE, or CARF or COA accredits the program itself, as an observation/holding bed program that provides psychiatric services.
- Program must meet state licensure/certification and Medicaid requirements (as applicable).
- Program must meet all applicable federal, state and local laws and regulations.
**Program** must attest to a formal written agreement with Joint Commission accredited Provider for emergency psychiatric, substance abuse, and/or medical care if such care is not available on site.

**Combination** of licensed mental health professional, mental health workers, and other appropriate paraprofessional staff.

**Community Mental Health Center**

Minimum criteria with the exception of:

- Licensed as a Mental Health Outpatient Facility.
- Formal CMS designation.

Behavioral Health Organizational Providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BCBST/BCT must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet BCBST/BCT standards. Standing with state and federal authorities and programs will be verified.

3. **Recredentialing Process**

All Medical or Behavioral Health Practitioners will be recredentialed at least every three years. The date of recredentialing will be based on the date of initial credentialing.

In addition to the information that will be verified by primary or secondary sources, BCBST/BCT will include and consider collected information regarding the participating Practitioner’s performance within the health plan, including information collected through the health plan’s quality management program. Recredentialing will begin approximately three (3) to six (6) months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and BCT will retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expeditiously with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProView™ website, https://proview.caqh.org, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The Provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

4. **BlueCross BlueShield of Tennessee/BlueCare Tennessee Approved Specialties**

BlueCross BlueShield of Tennessee/ BlueCare Tennessee recognizes and maintains the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Providers must designate a specialty on the credentialing application. To be listed in any BCBST/BCT Provider directory in the specialty requested, the Provider must meet one of the following requirements:

- Recognized Board Certification, or
- **Practitioners:** Successful completion of residency or fellowship in the applied specialty.
- **Other Health Care Professionals:** Licensure and additional certification, if applicable in the field of specialty.
American Board of Medical Specialties (ABMS)
I. American Board of Allergy and Immunology
   A. Allergy and Immunology
   B. Clinical and Laboratory Immunology
II. American Board of Anesthesiology
   A. Anesthesiology
   B. Critical Care Medicine
   C. Pain management
III. American Board of Colon and Rectal Surgery
   A. Colon and Rectal Surgery
IV. American Board of Dermatology
   A. Clinical and Laboratory Dermatological Immunology
   B. Dermatology
   C. Dermatopathology
   D. Pediatric Dermatology
V. American Board of Emergency Medicine
   A. Emergency Medicine
   B. Medical Toxicology
   C. Pediatric Emergency Medicine
   D. Sports Medicine
   E. Undersea-Hyperbaric Medicine
VI. American Board of Family Practice
   A. Family Practice
   B. Geriatric Medicine
   C. Sports Medicine
VII. American Board of Internal Medicine
   A. Adolescent Medicine
   B. Cardiovascular Disease
   C. Clinical & Laboratory Immunology
   D. Clinical Cardiac Electrophysiology
   E. Critical Care Medicine
   F. Endocrinology, Diabetes, and Metabolism
   G. Gastroenterology
   H. Geriatric Medicine
   I. Hematology
   J. Infectious Disease
   K. Internal Medicine
   L. Interventional Cardiology
   M. Medical Oncology
   N. Nephrology
   O. Pulmonary Disease
   P. Rheumatology
   Q. Sports Medicine
VII. American Board of Medical Genetics, Inc.
   A. Clinical Biochemical Genetics
   B. Clinical Cytogenetics
   C. Clinical Genetics
   D. Clinical Molecular Genetics
   E. Molecular Genetic Pathology
   F. PHD Medical Genetics
VIII. American Board of Neurological Surgery  
A. Neurological Surgery  

IX. American Board of Nuclear Medicine  
A. Nuclear Medicine  

X. American Board of Obstetric and Gynecology  
A. Critical Care Medicine  
B. Gynecologic Oncology  
C. Gynecology  
D. Maternal-Fetal Medicine  
E. Obstetrics  
F. Obstetrics and Gynecology  
G. Reproductive Endocrinology  

XI. American Board of Ophthalmology  
A. Ophthalmology  

XII. American Board of Orthopedic Surgery  
A. Hand Surgery  
B. Orthopedic Surgery  

XIII. American Board of Otolaryngology  
A. Otolaryngology  
B. Otology/Neurotology  
C. Pediatric Otolaryngology  
D. Plastic Surgery within the head and neck  

XIV. American Board of Pathology  
A. Anatomic & Clinical Pathology  
B. Anatomic Pathology  
C. Blood Banking Transfusion Medicine  
D. Chemical Pathology  
E. Clinical Pathology  
F. Cytopathology  
G. Dermatopathology  
H. Forensic Pathology  
I. Hematology  
J. Medical Microbiology  
K. Molecular Genetic Pathology  
L. Neuropathology  
M. Pediatric Pathology  

XV. American Board of Pediatrics  
A. Adolescent Medicine  
B. Clinical & Laboratory Immunology  
C. Developmental-Behavioral Pediatrics  
D. Medical Toxicology  
E. Neonatal-Perinatal Medicine  
F. Neurodevelopmental Disabilities  
G. Pediatric Cardiology  
H. Pediatric Critical Care Medicine  
I. Pediatric Emergency Medicine  
J. Pediatric Endocrinology  
K. Pediatric Gastroenterology  
L. Pediatric Hematology-Oncology  
M. Pediatric Infectious Disease  
N. Pediatric Nephrology  
O. Pediatric Pulmonology  
P. Pediatric Rheumatology  
Q. Pediatrics  
R. Sports Medicine
XVI. American Board of Physical Medicine and Rehabilitation
   A. Pain Management
   B. Pediatric Rehabilitation Medicine
   C. Physical Medicine and Rehabilitation
   D. Spinal Cord Injury Medicine

XVII. American Board of Plastic Surgery, Inc.
   A. Hand Surgery
   B. Plastic Surgery
   C. Plastic Surgery within the head and neck

XVIII. American Board of Preventive Medicine
   A. Aerospace Medicine
   B. Medical Toxicology
   C. Occupational Medicine
   D. Preventive Medicine
   E. Undersea and Hyperbaric Medicine

XIX. American Board of Psychiatry and Neurology
   A. Addiction Psychiatry
   B. Child And Adolescent Psychiatry
   C. Clinical Neurophysiology
   D. Forensic Psychiatry
   E. Geriatric Psychiatry
   F. Neurodevelopmental Disabilities
   G. Neurology
   H. Neurology with special qualification in Child Neurology
   I. Pain Management
   J. Pediatric Neurology
   K. Psychiatry

XX. American Board of Radiology
   A. Diagnostic Radiology
   B. Neuroradiology

XXI. American Board of Radiology (cont’d)
   C. Nuclear Radiology
   D. Pediatric Radiology
   E. Radiation Oncology
   F. Radiological Physics
   G. Radiology
   H. Vascular & Interventional Radiology

XXII. American Board of Surgery
   A. Hand Surgery
   B. Pediatric Surgery
   C. Surgery
   D. Surgical Critical Care
   E. Vascular Surgery

XXIII. American Board of Thoracic Surgery
   A. Thoracic Surgery

XXIV. American Board of Urology, Inc.
   A. Urology

American Osteopathic Association Boards (AOA)
I. American Osteopathic Board of Anesthesiology
   A. Addiction Medicine
   B. Anesthesiology
   C. Critical Care Medicine
   D. Pain Management
II. American Osteopathic Board of Dermatology
   A. Dermatology
   B. Dermatopathology
   C. MOHS-Micrographic Surgery

III. American Osteopathic Board of Emergency Medicine
   A. Emergency Medical Services
   B. Emergency Medicine
   C. Medical Toxicology
   D. Sports Medicine

IV. American Osteopathic Board of Family Practice
   A. Addiction Medicine
   B. Adolescent And Young Adult Medicine
   C. Family Practice
   D. Geriatric Medicine
   E. Sports Medicine

V. American Osteopathic Board of Internal Medicine
   A. Addiction Medicine
   B. Allergy/Immunology
   C. Cardiology
   D. Clinical Cardiac Electrophysiology
   E. Critical Care Medicine
   F. Endocrinology
   G. Gastroenterology
   H. Geriatric Medicine
   I. Hematology
   J. Hematology/Oncology
   K. Infectious Disease
   L. Internal Medicine
   M. Medical Oncology

V. American Osteopathic Board of Internal Medicine (cont’d)
   N. Nephrology
   O. Oncology
   P. Pulmonary Disease
   Q. Rheumatology
   R. Sports Medicine

VI. American Osteopathic Board of Neurology and Psychiatry
   A. Addiction Medicine
   B. Child And Adolescent Neurology
   C. Child And Adolescent Psychiatry
   D. Neurology
   E. Neurology/Psychiatry
   F. Psychiatry
   G. Sports Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine
    A. Neuromusculoskeletal Medicine
    B. Osteopathic Manipulative Medicine
    C. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine
    A. In Vivo And In Vitro Nuclear Medicine
    B. Nuclear Cardiology
    C. Nuclear Imaging and Therapy
    D. Nuclear Medicine
IX. American Osteopathic Board of Obstetrics and Gynecology
   A. Gynecologic Oncology
   B. Gynecology
   C. Maternal-Fetal Medicine
   D. Obstetrics
   E. Obstetrics And Gynecologic Surgery
   F. Obstetrics And Gynecology
   G. Reproductive Endocrinology

X. American Osteopathic Board of Ophthalmology and Otorhinolaryngology
   A. Facial Plastic Surgery
   B. Ophthalmology
   C. Otorhinolaryngology
   D. Otorhinolaryngology and Facial Plastic Surgery

XI. American Osteopathic Board of Orthopedic Surgery
   A. Orthopedic Surgery

XII. American Osteopathic Board of Pathology
   A. Anatomic Pathology
   B. Anatomic Pathology and Laboratory Medicine
   C. Blood Banking Transfusion Medicine
   D. Chemical Pathology
   E. Cytopathology
   F. Dermatopathology
   G. Forensic Pathology
   H. Hematology
   I. Laboratory Medicine
   J. Medical Microbiology
   K. Neuropathology

XIII. American Osteopathic Board of Pediatrics
   A. Adolescent and Young Adult Medicine
   B. Neonatology
   C. Pediatric Allergy and Immunology
   D. Pediatric Cardiology

XIII. American Osteopathic Board of Pediatrics (cont’d)
   E. Pediatric Endocrinology
   F. Pediatric Hematology/Oncology
   G. Pediatric Infectious Disease
   H. Pediatric Intensive Care
   I. Pediatric Nephrology
   J. Pediatric Pulmonary Medicine
   K. Pediatrics
   L. Sports Medicine

XIV. American Osteopathic Board of Preventive Medicine
   A. Occupational Medicine
   B. Preventive Medicine/Aerospace Medicine
   C. Preventive Medicine/Occupational-Environmental Medicine
   D. Public Health/General Preventive Medicine

XV. American Osteopathic Board of Proctology
   A. Proctology

XVI. American Osteopathic Board of Radiology
   A. Angiography and Interventional Radiology
   B. Body Imaging
   C. Diagnostic Radiology
   D. Diagnostic Ultrasound
   E. Neuroradiology
   F. Nuclear Radiology
   G. Pediatric Radiology
H. Radiation Oncology
I. Radiation Therapy
J. Radiology

XVII. American Osteopathic Board of Rehabilitation Medicine
   A. Rehabilitation Medicine
   B. Sports Medicine

XVIII. American Osteopathic Board of Surgery
   A. General Vascular Surgery
   B. Neurological Surgery
   C. Plastic and Reconstructive Surgery
   D. Surgery
   E. Surgical Critical Care
   F. Thoracic Cardiovascular Surgery
   G. Urological Surgery

American Board of Dental Sleep Medicine
   A. Dental Sleep Medicine

American Academy of Pediatrics (AAP)
   B. Pediatric Heart Surgery
   C. Pediatric Neurosurgery
   D. Pediatric Orthopedics
   E. Pediatric Urology

American Board of Oral and Maxillofacial Pathology
   A. Oral Pathology

American Board of Oral and Maxillofacial Surgery
   A. Oral and Maxillofacial Surgery

American Board of Orthodontics
   A. Orthodontics

American Board of Pain Management
   A. Pain Management

American Board of Pediatric Dentistry
   A. Pediatric Dentistry

American Board of Periodontology
   A. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric
   A. Podiatry (DPM)

American Board of Podiatric Surgery
   A. Podiatry (DPM)

American Board of Prosthodontics
   A. Prosthodontics
American Chiropractic Neurology Board, Inc.
A. Chiropractic Neurology

Other Health Care Professionals:
I. Accupuncturist
II. Audiology
III. Addictionologist (Non Psychiatrist)
IV. Associate Behavior Analyst
V. Certified Behavior Analyst
VI. Certified Registered Nurse Anesthetist (CRNA)
VII. Chiropractor (DC)
VIII. Chiropractor Neurologist
IX. Dietitian
X. Employee Assistance Professional Counselor
XI. Endodontist
XII. Family Practice with Obstetrical Fellowship
XIII. General Dentistry
XIV. General Practice
XV. Licensed Clinical social Worker (LCSW)
XVI. Licensed Professional Counselor
XVII. Licensed Senior Psychological Examiner (LSPE)
XVIII. Marriage and Family Therapist
XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
XX. Midwife (CNM)
XXI. Neuropsychology (Ph.D.)
XXII. Nurse (RN)
XXIII. Nurse Clinician
XXIV. Nurse Practitioner
XXV. Nurse Practitioner, Acute Care
XXVI. Nurse Practitioner, Adult Health
XXVII. Nurse Practitioner, Family Practice
XXVIII. Nurse Practitioner, Gerontology and Adult Health
XXIX. Nurse Practitioner, Neonatal
XXX. Nurse Practitioner, Oncology
XXXI. Nurse Practitioner, Pediatrics
XXXII. Nurse Practitioner, Psychological/Mental Health
XXXIII. Nurse Practitioner, Women’s Health
XXXIV. Nutrition
XXXV. Occupational Therapy (OT)
XXXVI. Optometry
XXXVII. Pastoral Counselor
XXXVIII. Pediatric Anesthesiology
XXXIX. Pediatric Genetics
XL. Pediatric Ophthalmology
XLI. Pediatric Plastic Surgery
XLII. Pharmacist – Clinical
XLIII. Pharmacist – Immunizing
XLIV. Physical Therapist (PT)
XLV. Physician Assistant (PA)
XLVI. Physician Assistant – Surgical Assist
XLVII. Professional Counselor
XLVIII. Prosthetist/Orthotist
XLIX. Psychiatrist
L. Psychologist or Psycholoanalyst

XVII-18
Credentialing Process for Medical Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensure that decisions are based on the most accurate, current information available. The following types of Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

Balance This Page
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Organizational Type | Requirements
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**Acute Care Facility** | 1) **TN: Licensed as Acute Care Facility**<br>Other States: Licensed in accordance with that state’s licensing laws<br>2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.<br>3) DEA certificate, if applicable<br>4) CLIA certificate, if applicable<br>5) Medicare Part A (new facilities which have not obtained subject to Committee exception)<br>6) TJC or AOA or CHAP or AAAHC, or Det Norske Veritas (lack of accreditation subject to Committee exception)<br>7) If not accredited, copy of State Site Survey required<br>8) Leapfrog Compliance, if available<br>9) General Liability Insurance<br>10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)<br>11) An attestation to the correctness and completeness of the application

**Ambulatory Infusion Center (AIC)** | 1) **TN: Licensed as Ambulatory Surgery Facility**<br>Other States: Licensed in accordance with that state’s licensing laws<br>2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.<br>3) Medicare Certificate<br>4) Accredited by BCBST/BCT approved accrediting body as an AIC<br>5) Medical Director credentialed by BCBST/BCT<br>6) General Liability Insurance<br>7) History of federal and/or state sanctions (Medicare or TennCare)<br>8) An attestation to the correctness and completeness of the application

**Ambulatory Surgical Facility** | 1) **TN: Licensed as Ambulatory Surgery Facility**<br>Other States: Licensed in accordance with that state’s licensing laws<br>2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.<br>3) CLIA Certificate, if applicable<br>4) TJC or AOA or CHAP or AAAHC or AAAASF and Medicare Part B with copy of site audit<br>5) General Liability Insurance<br>6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)<br>7) An attestation to the correctness and completeness of the application

**Birthing Centers** | 1) **TN: Licensed as Birthing Center**<br>Other States: Licensed in accordance with that state’s licensing laws<br>2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.<br>3) CLIA Certificate, if applicable<br>4) TJC or AOA or CHAP or AAAHC or Medicare Part B<br>5) General Liability Insurance<br>6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)<br>An attestation to the correctness and completeness of the application

**Dialysis Facility** | 1) **State of Tennessee End Stage Renal Disease (ESRD) Facility License**<br>Other States: Licensed in accordance with that state’s licensing laws<br>2) Not currently sanctioned by Medicare/Medicaid<br>3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.<br>4) Medicare Part A Certification<br>5) CLIA Certificate<br>6) General Liability Insurance<br>7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)<br>An attestation to the correctness and completeness of the application

Rev 12/18
<table>
<thead>
<tr>
<th>Type</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>DME Providers</td>
<td>1) <strong>TN: Licensed as a DME Provider</strong> Other States: Licensed in accordance</td>
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<td></td>
<td>with that state’s licensing laws</td>
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<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<td>3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-</td>
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<td>4) Medicare Part B required</td>
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<td></td>
<td>5) DEA certificate, if applicable</td>
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<td>6) Pharmacy License, if applicable</td>
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<td>7) TJC or CHAP or AAAHC, or BOC or The Compliance Team or ABC or NBAOS or</td>
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<td>CARF or HQAA or ACHC required</td>
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<td>8) General Liability Insurance</td>
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<td></td>
<td>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td>10) An attestation to the correctness and completeness of the application</td>
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<tr>
<td>Health Department</td>
<td>1) State Tort Insurance</td>
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<td>2) CLIA Certificate</td>
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<tr>
<td>Home Infusion Therapy</td>
<td>1) <strong>TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)</strong></td>
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<tr>
<td>Providers</td>
<td>Other States: Licensed in accordance with that state’s licensing laws</td>
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<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<td>4) Medicare Part B required</td>
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<td>5) DEA certificate, if applicable</td>
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<td>6) TJC or CHAP or AAAHC, collect but not required</td>
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<td>7) General Liability Insurance</td>
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<td>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td>9) An attestation to the correctness and completeness of the application</td>
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<tr>
<td>Home Health Providers:</td>
<td>1) <strong>TN: Licensed as a Home Health Provider</strong> Other States: Licensed in</td>
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<td>accordance with that state’s licensing laws</td>
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<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<td>3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-</td>
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<td>4) Medicare Part A required</td>
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<td>5) CLIA Certificate, if applicable</td>
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<td>6) TJC or CHAP or AAAHC, collect but not required</td>
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<td></td>
<td>7) If not accredited, copy of state or CMS site audit</td>
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<td></td>
<td>8) General Liability Insurance</td>
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<td>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td>10) An attestation to the correctness and completeness of the application</td>
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<tr>
<td>Hospice Provider</td>
<td>1) <strong>TN: Licensed as a Hospice Provider</strong> Other States: Licensed in accordance</td>
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<td>with that state’s licensing laws</td>
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<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<td>3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-</td>
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<td></td>
<td>4) Medicare Part A required</td>
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<td>5) CLIA Certificate, if applicable</td>
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<td></td>
<td>6) TJC or AOA or CHAP or AAAHC, collect but not required</td>
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<td>7) General Liability Insurance</td>
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<td>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<tr>
<td>Organizational Type</td>
<td>Requirements</td>
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</table>
| **Independent Lab** | **1) **\textit{TN: Licensed as a Laboratory}  
Other States: Licensed in accordance with that state’s licensing law.  
2) Not currently sanctioned by Medicare/Medicaid  
3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
4) History of Professional liability claims that resulted in settlements or judgments  
5) Medicare Part B  
6) TJC or CAP, collect if applicable but not required  
7) CLIA Certificate, Draw station – CLIA not required  
8) General Liability Insurance  
9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
10) An attestation to the correctness and completeness of the application |
| **Inpatient Rehabilitation Facility** | **1) **\textit{TN: Licensed as a Inpatient Rehabilitation Facility}  
Other States: Licensed in accordance with that state’s licensing laws  
2) Not currently sanctioned by Medicare/Medicaid  
3) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
4) Medicare Part A  
5) CLIA certificate, if applicable  
6) DEA certificate, if applicable  
7) TJC or CARF or AOA accreditation (no exception)  
8) General Liability Insurance  
9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
10) An attestation to the correctness and completeness of the application |
| **Non-Licensed DME Providers (Non-motorized equipment only)** | **1) **Not currently sanctioned by Medicare/Medicaid  
2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
3) History of Professional liability claims that resulted in settlements or judgments  
4) Medicare Part B  
5) TJC or CHAP or AAAHC, if applicable but not required  
6) General Liability Insurance  
7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
8) An attestation to the correctness and completeness of the application |
| **Orthotic/Prosthetic Supplier** | **1) **\textit{American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification}  
2) General Liability Insurance  
3) $1 million/$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage $500 thousand) and claims history. NPDB reports or self-reported.  
4) History of Professional liability claims that resulted in settlements or judgments  
5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
6) An attestation to the correctness and completeness of the application |
| **Outpatient Diagnostic** | **1) **$1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
2) History of Professional liability claims that resulted in settlements or judgments  
3) Medicare Part B Certification  
4) General Liability Insurance  
5) CLIA certification, if applicable  
6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
7) An attestation to the correctness and completeness of the application |
<table>
<thead>
<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>Outpatient Rehabilitation Facility</td>
<td>1) Not currently sanctioned by Medicare/Medicaid</td>
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<tr>
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<td>2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.</td>
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<td>3) History of Professional liability claims that resulted in settlements or judgments</td>
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<td>4) Medicare Part A <em>(If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit)</em></td>
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<td>5) TJC or CORF, collect but not required.</td>
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<td>6) CLIA required if onsite laboratory.</td>
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<td>7) General Liability Insurance</td>
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<td>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td></td>
<td>9) An attestation to the correctness and completeness of the application</td>
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</table>

Pain Management Center

1) **TN: Licensed as an Ambulatory Surgical Facility**
   Other States: Licensed in accordance with that state’s licensing laws
2) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.
3) DEA certificate, if applicable
4) CARF accreditation or American Academy of Pain Management accreditation
5) General Liability Insurance
6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
7) An attestation to the correctness and completeness of the application

Professional Support Services Licensure (PSSL)

1) **TN: Licensed as a Professional Support Service**
   Other States: Licensed in accordance with that state’s licensing laws
2) $1 million/$2 million Malpractice and claims history. NPDB reports or self-reported.
3) Medicare certificate
4) DEA certificate, if applicable
5) Member of DIDS (Division of Intellectual Disability Services)
6) History of Medicare/Medicaid sanction – no prior history
7) General Liability Insurance
8) An attestation to the correctness and completeness of the application

Skilled Nursing Facility (No Swing Beds)

1) **TN: Licensed as a Skilled Nursing Facility**
   Other States: Licensed in accordance with that state’s licensing laws
2) Not currently sanctioned by Medicare/Medicaid
3) $1 million/$3 million Malpractice as consistent with TCA 71-5-1412 and claims history. NPDB reports or self-reported.
4) Medicare Part A
5) CLIA, if applicable
6) DEA certificate, if applicable
7) TJC or CHAP or AAAHC or AOA, collect but not required
8) If not accredited, copy of state or CMS site audit
9) General Liability Insurance
10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
11) An attestation to the correctness and completeness of the application

Urgent Care Centers

1) State Business License
2) Oversight by a Medical Director that is currently credentialed by BCBST/BCT
3) Accreditation by Urgent Care Association of America (UCAOA) or a certificate from Certified Urgent Care (CUC) Program
4) $1 million to $3 million Malpractice and claims history. NPDB reports or self-reported.
5) History of federal and/or state sanctions (Medicare, Medicaid or TennCare)
6) General Liability Insurance
7) An attestation to the correctness and completeness of the application
Sleep Labs

1) $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.
2) Medicare Certification Part B
3) Accreditation by American Academy of Sleep Medicine (AASM) or JC
4) General Liability Insurance
5) History of any professional liability claims that resulted in settlements or judgments
6) Medical Director who is a Diplomat of the ABSM
7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
8) An attestation to the correctness and completeness of the application

Organizational Providers must be recredentialed every three (3) years to meet federal and state regulatory guidelines. During the recredentialing process the initial credentialing information must be resubmitted.

6. BCBST/BCT Tennessee Recognized Accrediting Bodies

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Association for Marriage and Family Therapy (AAMFT)
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
- American Board of Dental Sleep Medicine
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American College of Radiology (ACR)
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Psychological Association (APA)
- American Society of Addiction Medicine (ASAM)
- American Speech-Language-Hearing Association (ASHA)
- Board for Orthotist/Prosthetist Certification (BOC)
- Certified Clinical Mental Health Counselor (CCMHC)
- Board of Certification (BOC)
- (COLA) formerly known as the Commission on Office Laboratory Accreditation
- College of American Pathologists (CAP)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Division of TennCare or Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Board for Certified Counselors (NBCC)
5. BCBST/BCT Tennessee Recognized Accrediting Bodies (cont’d)

- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- National Society of Genetic Counselors (NSGC)
- Pediatric Nursing Certification Board
- The Compliance Team, Inc.
- The Joint Commission (TJC)
- The Medical Quality Commission (TMQC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare
- Urgent Care Association of America (UCAOA)
- Certified Urgent Care Program (CUC)

D. Practice Site/Medical Record Standards

Practice Site Standards
BlueCross BlueShield of Tennessee/BlueCare Tennessee has adopted practice site standards for all credentialed Practitioners that provide ambulatory care to Members. These standards were developed to assure Members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) monitors Member complaints received regarding the quality of office sites. Practitioners will be advised in writing of specific complaints received about the quality of the office site. Credentialed Practitioners with two (2) office quality complaints within a six (6) month period, that include but is not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within sixty (60) days of 2nd Member complaint. CRM investigates the severity of all complaints received. BlueCross BlueShield of Tennessee/BlueCare Tennessee may act on one complaint if it is determined necessary.

Primary Care Provider (PCP) practice sites and OB/GYN sites not previously reviewed and currently occupied by a network Practitioner will be evaluated prior to, or within sixty (60) days of initial credentialing.

Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to Clinical Risk Management Committee and re-audited within six (6) months. Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Practice Improvement Plan and a 2nd re-audit planned within six (6) months.

The following current established site review standards have been adopted by BCBST/BCT. Compliance with all required elements noted with an asterisk (*), and an overall score of 80 percent achieved is required to meet these site review standards. These standards are subject to change and revisions will be posted in quarterly updates.
### Site Review Standards

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<tr>
<td>* 1.</td>
<td>The office is to be handicap accessible.</td>
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<td>* 2.</td>
<td>The office is to be clean, and organized, with adequate examining room and waiting room space.</td>
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<td>* 3.</td>
<td>The office should have adequate lighting in waiting room and treatment area.</td>
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<td>* 4.</td>
<td>Examining rooms should be designed for patient privacy.</td>
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<td>5.</td>
<td>There should be evidence of compliance with BlueCross BlueShield of Tennessee/BlueCare Tennessee appointment availability standards for routine and urgent care.</td>
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<td>* 6.</td>
<td>Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the Practitioner on call.</td>
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<td>* 7.</td>
<td>There should be an individual medical record for each patient.</td>
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<td>* 8.</td>
<td>Current medical records should be available at the site where services are provided and readily accessible.</td>
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<td>* 9.</td>
<td>Medical records should be kept in a secure location. Sites with Electronic Medical Records should provide evidence of a secure off site record retention/recovery process.</td>
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<td>* 10.</td>
<td>There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).</td>
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<td>* 11.</td>
<td>There should be evidence of a fire safety/emergency action plan with evidence of staff education. This plan must be written at locations with 10 or more employees. Pathways to doors should be clear and well marked.</td>
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</tbody>
</table>
| * 12. | Emergency Supplies and procedures should be available for scope of practice. Minimum requirements include:  
- Epinephrine and O₂ for PCP sites  
- Delivery kit for OB/GYN  
- Crash cart and O₂ at sites that perform stress test or services that require sedation. |
| * 13. | The office has infection control procedures that include appropriate disposal of bio-hazardous material. Hand washing facilities should be in/near treatment rooms and OSHA standards and MSDS/SDS information should be available to staff. |
| * 14. | There should be a process for the appropriate disposal of needles and other sharps. |
| 15. | There should be a process for inventory control of all stock and sample medications. |
| * 16. | There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs. |
| * 17. | Controlled substances must be maintained in a locked area. |
| * 18. | Evidence of CLIA registration with site-specific address is required for any practice location where lab is performed. |
| * 19. | If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection. |
| 20. | Radiology technique should be posted near the radiology equipment if not generated by radiology equipment. |
| * 21. | For Physician Extenders, there should be a protocol on site and evidence of supervising Physician oversight, as required by practice type and state regulations. |
| 22. | There should be a sign posted that Physician Extenders may provide care, where applicable. |
| 23. | Professional staff should be licensed appropriately with evidence of licensure on file. |
| 24. | Member rights and responsibilities should be posted or otherwise made available to Members. |
**Comprehensive Medical Record Standards**

Network Practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care Practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than five (5) percent of credentialed Primary Care Practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with Practitioner or Practitioner representative if applicable. In addition, medical record reviews will be performed during the annual HEDIS® project and analysis performed to identify Practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed Practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

**Medical Record Keeping Practices**

1. Medical records should be legible.
2. Member identification is to be on each page of the record.
3. Each recorded chart entry is to be dated and identified by the author. Stamped signatures are not acceptable.
4. The medical records should be readily accessible to the Practitioner during normal office hours.

**Documentation**

5. All medical records are to contain a current Member problem list, which addresses chronic and significant recurrent/acute conditions.
6. All medication allergies, absence of allergies, **and/or adverse reactions** are to be consistently documented and prominently displayed in all medical records.
7. An initial history and physical examination should be documented for new patients within 12 months of Member first seeking care, or within 3 visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age 6 should be documented.
8. Each medical record is to contain an updated list of medications the Member is taking, or documentation that the Member is presently not taking any medications.
9. Each medical record is to contain tobacco, alcohol, and/or substance use history (for Members 12 years and over and seen three (3) or more times).
10. The medical record of all Members age 18 years and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare Members.
11. If the Member has executed an advance directive, a copy should be on file within the office.

**Appropriateness of Care**

12. Each visit should include documentation of Member’s chief complaint or purpose for visit. Clinical assessment and physical examination should be documented and correspond to Member’s stated complaint or visit purpose and/or ongoing care for chronic illnesses.
13. Working diagnosis or medical impressions that logically follow from the clinical assessment and physical examination should be recorded.
14. Rationale for treatment decisions should appear Medically Appropriate and be substantiated by documentation in the record, with laboratory tests performed at appropriate intervals.
15. Records should substantiate the Member’s clinical problems and treatment in a manner such that another Practitioner can determine the Member’s overall clinical course under the reviewed Practitioner’s management.
Continuity and Coordination of Care
16. There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone calls or return office visits.
17. Medical records should contain documentation of appropriate use of consultants, which includes Behavioral Health Providers, and documentation of medical services performed by a referral specialist/Practitioner.
18. If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

Education & Preventive Care
19. Each medical record should contain evidence that age/sex-appropriate preventive screenings/immunizations are offered in accordance with Clinician's Handbook of Preventive Services or the American Academy of Pediatrics, as applicable.
20. Care for high-risk conditions should be documented in accordance with BlueCross BlueShield of Tennessee’s Health Care Practice Recommendations.
21. There should be documentation of Member education/instructions.

TennCare Kids Medical Record Standards
Clinical personnel perform onsite medical record reviews of Primary Care Providers that provide preventive care to Members under the age of 21 to evaluate compliance with Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) requirements and to share additional education and resources. Reviews are performed every two (2) years, but may also be requested anytime by the Clinical Risk Management Department.

Reviews are conducted according to the Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual unless more current published American Academy of Pediatrics (AAP) guidelines are available. The manual provides detailed information for each of the elements listed below and is available at http://tnaap.org.

Results and suggestions for improvements, if applicable, will be shared with the Practitioner, or their representative at the conclusion of the review. Practitioners that fail to meet the 88 percent threshold required for compliance with TennCare Kids standards shall receive a letter requesting information regarding actions taken to improve performance and documentation as a result of this review. A re-audit will be scheduled within 12 months of Practitioner response.

Practitioners that fail to meet the minimum compliance standard on re-audit will receive additional education regarding deficiencies and a re-audit planned within twelve (12) months. Failure to meet compliance threshold with 2nd re-audit will result in referral to the Clinical Risk Management Committee for evaluation and communication of a Practice Improvement Plan.

Age appropriate elements, identification of risk factors, periodicity for procedures and immunizations should be provided at each TennCare Kids encounter based on the most current American Academy of Pediatrics Recommendations for Pediatric Health Care. Documentation should provide reasons for not performing any element, or Member refusal of any or all elements of this exam.

1. There should be a comprehensive health and development history. This should be updated with documentation of an interval history, developmental/behavioral surveillance and screenings as appropriate for age and risk factors.
2. There should be evidence of a comprehensive unclothed physical examination.
3. There should be evidence of age-appropriate subjective/objective hearing exam.
4. There should be evidence of age-appropriate subjective/objective vision exam.
5. Immunizations should be provided as appropriate for age and risk factors. Documentation of immunizations administered by other Providers should be requested and available in the medical record (record entry or photocopy) with antigen and date of administration noted.
6. Procedures and tests should be performed as appropriate for age and risk factors, including lead screening, which is required at age twelve (12) and twenty-four (24) months of age.
7. Anticipatory guidance and health education should be provided as appropriate for age.
8. There should be evidence of an oral/dental screening with a referral for dental health care starting at age 3 or earlier as Medically Necessary.
9. There should be evidence of appropriate referrals to other health care Practitioners, including Behavioral Health Providers, or for ancillary care as result of problems identified.
Facility Site Standards

Non-accredited facilities applying for initial credentialing with BCBST/BCT networks must meet and maintain compliance with the site standards listed below.

Non-compliant sites for currently credentialed Providers will be referred to the BCBST/BCT Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed Providers until BCBST/BCT facility site standards are met.

Physical Assessment
1. The facility is to be handicap accessible.
2. The facility should be clean and organized with adequate lighting and work space in treatment rooms to conduct patient exams effectively.

After Hours Coverage
3. Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping
4. There should be an individual medical record for each Member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

Safety
8. Emergency supplies and procedures should be available for the scope of practice.
9. Policy and procedures should be available and reviewed annually regarding administrative, operational, safety, disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management and infection control.
11. There should be infection control measures consistent with OSHA guidelines.
12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if lab is performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological technique should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.
19. The facility should maintain equipment in a safe manner consistent with the manufacturer's recommendations.
20. Member Rights and Responsibilities should be posted, or available in the facility.
21. Professional staff should be licensed appropriately with evidence of licensure on file.
22. The facility should have a defined process to ensure professional performance of its staff by:
   a) Completing credentialing process for independent Practitioners.
   b) Completing credentialing functions according to state, federal and NCQA standards.
   c) Utilizing the current license, relevant training and experience, current competence and privileges at a hospital in the credentialing process.

The facilities’ files will be audited by a BCBST/BCT Credentialing Representative to ensure the credentialing process meets the above criteria.
**XVIII. CoverKids**

### A. Introduction

BlueCare Tennessee administers the CoverKids program on behalf of the State of Tennessee. Effective July 1, 2016, CoverKids is supported by BlueCare Tennessee’s CoverKids Network. The CoverKids program provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over.

The CoverKids plan provides free, comprehensive health coverage for qualifying children under age 19 years and pregnant women. The coverage includes an emphasis on preventive health services and coverage for Physician services, hospital visits, vaccinations, well-child visits, developmental screenings*, behavioral health care services, pharmacy, prenatal and postpartum care, and vision and dental care. CoverKids does not cover any chiropractic, routine vision and dental care for pregnant women 19 years and older. There are low co-pays for medical services, though well-child visits and immunizations are covered at 100 percent.

CoverKids Members may obtain a second opinion prior to undergoing an elective medical service. The second opinion is covered as long as the Member sees a participating CoverKids Network Provider. If a CoverKids patient wishes to obtain a second opinion, please refer him/her to a CoverKids Network Provider. If a CoverKids Network Provider is not available, ask the Member to call Member Services at 1-888-325-8386 and BlueCare Tennessee’s Member Services will find a qualified Provider at no additional cost to him or her.

*Providers performing developmental/behavioral screenings for CoverKids children should:

- use a standardized screening tool with interpretation and report;
- indicate in child’s medical record a developmental screening was performed;
- document in child’s medical record screening date, tool utilized and results; and
- file charges on a CMS-1500 claim form utilizing CPT® code 96110.

### B. Eligibility

CoverKids is designed for uninsured children under age 19 years and pregnant women age 19 years or older whose families earn within 250 percent of the federal poverty level.

Eligibility criteria are:

- Under age 19 years;
- A Tennessee resident;
- U.S. citizen or qualified legal alien;
- Not eligible for TennCare;
- Household income up to 250 percent of federal poverty level; and
- Pregnant women at or below 250 percent of the federal poverty level who meet other eligibility criteria.
C. Application

- **Child Coverage**
  Beginning December 16, 2015, all non-pregnant children/adolescents seeking CoverKids coverage must apply through the Federally Facilitated Marketplace (FFM) at [www.healthcare.gov](http://www.healthcare.gov) or by calling toll-free at 1-800-318-2596.

- **Pregnant Women**
  Beginning January 1, 2016, four different CoverKids application options are available to pregnant women:

  1. An application may be filed online or by phone through the FFM at [www.healthcare.gov](http://www.healthcare.gov) or toll-free at 1-800-318-2596.
  2. In-person application assistance is available at local health departments throughout the state;
  3. A paper application with a signed cover page* may be faxed to CoverKids at 1-866-913-1046; or
  4. A paper application with a signed cover page* may be mailed to CoverKids at P.O. Box 305230, Nashville, TN 37230-5230.

  *Note*: Providers must report ALL non-live births to CoverKids.

* The paper application and cover page can be found online at [https://www.tn.gov/coverkids/coverkids/application.html](https://www.tn.gov/coverkids/coverkids/application.html) or by calling 1-866-620-8864.

D. Member ID Card

Each CoverKids Member receives a plastic Member ID card. The cards differ depending on the Member’s coverage.

**CoverKids under the age of 19 ID card sample**

**CoverKids pregnant women ID card sample**

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## E. Benefits

### CoverKids Benefits

<table>
<thead>
<tr>
<th></th>
<th>BENEFIT LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Office/Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Visit</strong></td>
<td>$15 Co-Pay</td>
</tr>
<tr>
<td>Office visits with family practice, general practice, internal medicine, OB/GYN, pediatrics, and walk in clinics</td>
<td></td>
</tr>
<tr>
<td>Includes nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care Provider</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Visit and Outpatient Surgery</strong></td>
<td>$20 Co-Pay</td>
</tr>
<tr>
<td>Office visits with any specialty Provider</td>
<td></td>
</tr>
<tr>
<td>Outpatient surgeries including invasive diagnostic services (e.g. colonoscopy) - Single co-pay per date of service</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health (Mental Health and Substance Abuse) Services</strong></td>
<td>$15 Co-Pay</td>
</tr>
<tr>
<td>Office visits</td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental health and substance abuse - Single co-pay per date of service</td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractors</strong></td>
<td>$15 Co-Pay</td>
</tr>
<tr>
<td>Only covered for children under age 19</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation and Therapy Services</strong></td>
<td>$15 Co-Pay</td>
</tr>
<tr>
<td>Including Speech, Physical and Occupational</td>
<td></td>
</tr>
<tr>
<td>Limited to 52 visits per therapy type per Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy - Benefits managed by Express Scripts (ESI)</strong></td>
<td>$5 generic</td>
</tr>
<tr>
<td>30 and 90-Day Supply/Specialty Pharmacy Drugs</td>
<td>$20 preferred</td>
</tr>
<tr>
<td>$40 non-preferred</td>
<td>No Co-Pay</td>
</tr>
<tr>
<td>$5 non-preferred</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Emergency Care</strong></td>
<td>$50 Co-Pay</td>
</tr>
<tr>
<td>Emergency Room Visit deemed as NOT a True Medical Emergency</td>
<td></td>
</tr>
<tr>
<td>Facility (Medical &amp; Behavioral Health [Mental Health and Substance Abuse]), including Urgent Care</td>
<td></td>
</tr>
<tr>
<td>MUST be an In Network Provider. If Out of Network Provider, CoverKids will NOT pay.</td>
<td></td>
</tr>
</tbody>
</table>

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**XVIII-3**
## CoverKids Benefits

### Inpatient Stays

| Inpatient Facility (Medical and Behavioral Health [Mental Health and Substance Abuse]) | BENEFIT LEVEL |
|---|---|---|
| Co-Pay waived if readmitted within 48 hours of initial visit for same episode of illness or injury | $100 Co-Pay per admission | $5 Co-Pay per admission | No Co-Pay |
| Rehabilitation services | | | |
| Mental Health and Substance Abuse Treatment | | | |

### Vision Services - These Services are only eligible for Children under 19. When both frames and lenses are ordered at the same time, one Co-Pay is charged

| Prescription Eyeglass Lenses | BENEFIT LEVEL |
|---|---|---|
| $15 Co-Pay | $15 Co-Pay | No Co-Pay |
| $85 Max Benefit | $85 Max Benefit | |

| Prescription Contact Lenses in lieu of Eyeglass Lenses | BENEFIT LEVEL |
|---|---|---|
| $15 Co-Pay | $5 Co-Pay | No Co-Pay |
| $150 Max Benefit | $150 Max Benefit | |

| Frames | BENEFIT LEVEL |
|---|---|---|
| $15 Co-Pay | $5 Co-Pay | No Co-Pay |
| $100 Max Benefit | $100 Max Benefit | |

The following grid identifies CoverKids services that do NOT require a co-pay:
<table>
<thead>
<tr>
<th>The following services do NOT require a Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
</tr>
<tr>
<td>• Well-baby, well-child visits</td>
</tr>
<tr>
<td>• Annual physical exam</td>
</tr>
<tr>
<td>• Annual well-woman exam including, but not limited to, family planning and pap tests</td>
</tr>
<tr>
<td>• Immunizations</td>
</tr>
<tr>
<td>• Annual hearing and vision screening</td>
</tr>
<tr>
<td>• Screenings including colonoscopy, colorectal, labs, nutritional guidance, Sexually Transmitted Disease (STD), cancer and other screenings</td>
</tr>
<tr>
<td><strong>Office/Outpatient Services</strong></td>
</tr>
<tr>
<td><strong>X-Ray, Lab and Diagnostics</strong></td>
</tr>
<tr>
<td>• Including reading, interpretation of results, dialysis, radiation, cobalt, and radioisotope therapy</td>
</tr>
<tr>
<td>• Including MRIs, cat scans and nuclear medicine</td>
</tr>
<tr>
<td><strong>Allergy Testing and Allergy Injections</strong></td>
</tr>
<tr>
<td><strong>Chemotherapy and Radiation Therapy</strong></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
</tr>
<tr>
<td><strong>Emergency Room Visit Deemed as an Emergency</strong></td>
</tr>
<tr>
<td>• Medical and Behavioral Health (Mental Health and Substance Abuse)</td>
</tr>
<tr>
<td><strong>Services Received at an Outpatient Facility</strong></td>
</tr>
<tr>
<td><strong>Physician Charges (Medical and Behavioral Health [Mental Health and Substance Abuse])</strong></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
</tr>
<tr>
<td>• Limited to 100 days per Calendar Year following approved hospitalization</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
</tr>
<tr>
<td><strong>Maternity Related Facility and Provider</strong></td>
</tr>
<tr>
<td>• Maternity Visits prenatal and postpartum care</td>
</tr>
<tr>
<td>• Hospital admission for delivery</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
</tr>
<tr>
<td>• Including prosthetics/orthotics</td>
</tr>
<tr>
<td>• Hearing aids are limited to 1 per ear per Calendar Year up to the age 5; then 1 per ear every 2 years thereafter</td>
</tr>
<tr>
<td><strong>Supplies (31 day supply)</strong></td>
</tr>
<tr>
<td><strong>Ambulance - Land and Air</strong></td>
</tr>
<tr>
<td>• Emergency to the nearest facility</td>
</tr>
<tr>
<td>• From the scene of an accident to the nearest facility</td>
</tr>
<tr>
<td>• Facility to facility when medically appropriate</td>
</tr>
</tbody>
</table>
The following services do NOT require a Co-Pay

Other Services (cont’d)

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
</tr>
<tr>
<td>- Home Nursing Care limited to 125 visits per Calendar Year</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
</tr>
<tr>
<td>Hospice</td>
</tr>
<tr>
<td>- Co-Pay waived for all services if Member is under hospice care</td>
</tr>
<tr>
<td>Diabetic Self-Management Training and Education</td>
</tr>
<tr>
<td>Vision Services - These Services are only eligible for Members 18 years and under.</td>
</tr>
<tr>
<td>Annual Vision Exam</td>
</tr>
<tr>
<td>- Including refractive exam and annual glaucoma testing</td>
</tr>
<tr>
<td>- Must go to an In-Network Provider</td>
</tr>
</tbody>
</table>

**Covered Services and Limitations on Covered Services**

The Plan will pay the CoverKids Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described below and provided in accordance with the reimbursement schedules. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with the Medical Policies and medical management procedures.

Covered Services and Limitations set forth are arranged according to:
- Eligible Providers; and
- Eligible Services

Network Providers should not bill the Member for the amount above the CoverKids Maximum Allowable Charge.

Out-of-Network Providers do not have a contract with the plan. This means the Provider will be able to charge the Member more than the amount set by the plan in their contracts. With Out-of-Network Providers, the Member will be responsible for the full amount that is charged.

Obtaining services not listed in the Member Handbook or not in accordance with Our Medical Management Policies and Procedures may result in the denial of payment. Obtaining prior authorization is not a guarantee of coverage. Our Medical Policies can help the Provider determine if a proposed service will be covered.

Referrals are not required for specialty care including well woman care.

**Eligible Providers of Service**

A. Practitioners
   All services must be rendered by a Practitioner listed in the Directory of Network Providers. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner, or the delegate actually billing for the Practitioner, and be within the scope of his or her licensure.

B. Other Providers of Service
   An individual or facility, other than a Practitioner, duly licensed to provide Covered Services and listed in the Directory of Network Providers.

C. Out-of-Network Providers

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No benefits will be paid for services received from Out-of-Network Providers under this Plan. There are two exceptions to this:
1. There are benefits for Out-of-Network, hospital-based Practitioners in a Network facility.
2. In a true Emergency, there are benefits for Out-of-Network Providers (Facility and Practitioners).

Eligible Services:
A. Practitioner Office Services
   Medically Necessary and Appropriate services in a Practitioner’s office.
   1. Covered
      a. Services and supplies for the diagnosis and treatment of illness or injury, including those relating to hearing, speech, voice or language other than for a functional nervous disorder.
      b. Injections and medications administered in a Practitioner’s office, except Specialty Pharmacy Products.
      c. Casts and dressings.
      d. Nutritional guidance and education.
      e. Foot care necessary to prevent the complications of an existing disease state.
      f. Second opinions given by a Practitioner who is not in the same medical group as the Practitioner who rendered the initial diagnosis or initially recommended surgery. If an in-network Practitioner is not available to provide a second opinion, we will arrange for the Member to receive a second opinion for an out-of-network Practitioner at no cost to the Member than if the second opinion had been obtained from an in-network Practitioner.
      g. Emergency conditions presenting to the Practitioner’s Office.
      h. Pre- and post-natal maternity care, including complications of pregnancy, including the initial diagnosis of a pregnancy.
   2. Exclusions
      a. Office visits and physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.
      b. Routine foot care for the treatment of: 1) flat feet; 2) corns; 3) bunions; 4) calluses; 5) toenails; 6) fallen arches; and 7) weak feet or chronic foot strain.

B. Preventive Services
   Medically Necessary and Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits and services are based on the Plan’s Medical Policy guidelines, the American Academy of Pediatrics guidelines or the United States Preventive Services Task Force (USPSTF).
   1. Covered
      a. Periodic examinations, including Well-Woman examinations, and x-ray and lab screenings associated with preventive care. Referrals or prior authorizations are not required for routine and preventive women’s health services, including, but not limited to prenatal care, breast exams, mammograms and pap tests.
      b. Recommended and appropriate immunizations (including influenza immunizations).
      c. Vision and hearing screenings performed by the Physician during the preventive health exam.
   Some services are not needed every year, or may be appropriate only for people of particular age groups, gender, or those who meet other specific health criteria.
   2. Exclusions
      a. Immunizations needed for foreign travel.
      b. Office visits and physical exams for: (1) school activities; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings; and (7) related immunizations and tests.
      c. Preventive services not listed as Covered.
      d. Services not provided in accordance with the Plan’s Medical Policy guidelines, the American Academy of Pediatrics guidelines or the United States Preventive Services Task Force (USPSTF).
C. Office Surgery/Procedures
Medically Necessary and Appropriate surgeries/procedures performed in a Practitioner’s office. Office Surgeries can include excisions, incisions, biopsies, injection treatments, application of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).

1. Covered
   a. Excision of skin lesions and incisions.
   b. Repair of lacerations.
   c. Removal of foreign bodies from skin, eyes, or orifices.
   d. Sigmoidoscopy, pharyngoscopy, or other endoscopies.
   e. Biopsies.
   f. Colposcopy.
   g. Incision and drainage of abscess.
   h. Cyst aspiration.
   i. Joint injection and aspiration.
   j. Toenail excision.
   k. Cryosurgery of skin lesions and cervical lesions.
   l. Casting and splinting.

D. Special Surgical Procedure – Bariatric Surgery
The Plan will cover as outlined below, four surgical procedures for treatment of morbid obesity provided the adolescent is deemed physically and psychologically mature by a licensed Provider:
   a. Vertical banded gastroplasty accompanied by gastric stapling.
   b. Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum.
   c. Gastric banding.
   d. Duodenal switch/biliopancreatic bypass: this procedure is only appropriate for persons with a BMI in excess of 60. See (a.)(4) below.

The following criteria must be met before benefits are available for the procedures listed above:
   m. Presence of morbid obesity that has persisted for at least five years, defined as either:
      1) Body mass index (BMI) exceeding 40; or
      2) More than 100 pounds over one’s ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or
      3) BMI greater than 35 in conjunction with the following severe co-morbidities that are likely to reduce life expectancy
         (a) Coronary artery disease; or
         (b) Type 2 diabetes mellitus; or
         (c) Obstructive sleep apnea; or

The following criteria must be met before benefits are available for the procedures listed above:

D. Special Surgical Procedure – Bariatric Surgery
   (d) Three or more of the following cardiac risk factors (cont’d):
      (i) Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)
      (ii) Low high density lipoprotein cholesterol (HDL less than 40mg/dL)
      (iii) Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)
      (iv) Current cigarette smoking
      (v) Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)
      (vi) Family history of early cardiovascular disease in first-degree relative
          (myocardial infarction at age under 50 in male relative or at age under 65 for female relative)

4) BMI exceeding 60 for consideration of the Duodenal Switch/Biliopancreatic Bypass procedure.
   a. History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two years prior to surgery, and must be documented by an attending Physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten (10) percent of body weight over a six-month period and maintain weight loss.)
   b. There must be documentation of medical evaluation of the individual for the condition of morbid obesity and/or its co-morbidities by a Physician other than the operating surgeon.
E. Inpatient Hospital Services
1. Covered
   a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units.
   b. Attending Practitioner’s services for professional care.
   c. Observation stays.
   d. Blood/plasma is covered unless free.
   e. Maternity and delivery services, including complications of pregnancy.
2. Exclusions
   a. Inpatient stays primarily for therapy (such as physical or occupational therapy).
   b. Services that could be provided in a less intensive setting.
   c. Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.
   d. Private duty nursing care

F. Hospital Emergency Care Services
   Medically Necessary and Appropriate healthcare services and supplies furnished in a Hospital which are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol.
1. Covered
   a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Emergency condition.
   b. Practitioner services.
2. Exclusions
   a. Services received for inpatient care or transfer to another facility once medical condition has stabilized, unless Prior Authorization is obtained from the Plan within 24 hours or the next working day.

G. Ambulance Services
   Medically Necessary and Appropriate land transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the Member.
1. Covered
   a. Medically Necessary and Appropriate land or air transportation from the scene of an accident or emergency to the nearest appropriate facility or from facility to facility as Medically Appropriate.
2. Exclusions
   a. Transportation for the Member’s convenience.
   b. Transportation that is not essential to reduce the probability of harm to the Member.
   c. Services when Member is not transported to a facility.

H. Outpatient Facility Services
   Medically Necessary and Appropriate diagnostics, therapies and surgery occurring in an outpatient facility which includes: (1) outpatient surgery centers; (2) the outpatient center of a hospital; and (3) outpatient diagnostic centers.
1. Covered
   a. Practitioner services.
   b. Outpatient diagnostics (such as x-rays and laboratory services).
   c. Outpatient treatments (such as medications and injections).
   d. Outpatient surgery and supplies.
   e. Observations stays.
   f. Rehabilitative therapies.
   g. Maternity and Delivery Services (including complications of pregnancy).
2. Exclusions
   a. Vasectomies.
b. Services that could be provided in a less intensive setting.

I. Behavioral Health

Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Prior Authorization is required for Inpatient Services.

1. Covered
   a. Inpatient including Residential Treatment Center and outpatient services for care and treatment of mental health disorders and substance abuse disorders.
   b. Applied Behavior Analyst (ABA) services
   c. Continuous Treatment Team (CTT)
   d. Comprehensive Child and Family Treatment (CCFT)

2. Exclusions
   a. Pastoral counseling.
   b. Marriage and family counseling without a behavioral health diagnosis.
   c. Vocational and educational training and/or services.
   d. Custodial or domiciliary care.
   e. Services related to Mental Retardation, Learning Disorders or Developmental Disabilities, Disorders or Delays as described in the International Classification of Disease Manual (ICD)
   f. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
   g. Any care in lieu of legal involvement or incarceration.
   h. Hypnosis or regressive hypnotic techniques.
   i. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.
   j. Methadone maintenance therapy.
   k. Services that could be provided in a less intensive setting.
   l. Any International Classification of Disease (ICD) codes that are not included in the appropriate code range.

J. Family Planning and Reproductive Services

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases which may adversely affect fertility.

1. Covered
   a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing.
   b. Services or supplies for the evaluation of infertility.
   c. Medically Necessary and Appropriate termination of a pregnancy.
   d. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion

2. Exclusions
   a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments.
   b. Services or supplies for the reversals of sterilizations.
   c. Induced abortion unless: the pregnancy is the result of an act of rape or incest or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a Physician, place the woman in danger of death unless the abortion is performed.

K. Reconstructive Breast Surgery

Medically Necessary and Appropriate surgical procedures intended to restore normal form or function.
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1. Covered  
   a. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy) 
      including surgery on the non-diseased breast needed to establish symmetry between the 
      two breasts.

2. Exclusions  
   a. Services, supplies or prosthetics primarily to improve appearance.
   b. Surgeries to correct or repair the results of a prior surgical procedure, the primary 
      purpose of which was to improve appearance.
   c. Surgeries and related services to change gender.
   d. Any other reconstructive surgery.

L. Skilled Nursing/Rehabilitative Facility Services  
Medically Necessary and Appropriate Inpatient care provided to Members requiring medical, 
rehabilitative or nursing care in a restorative setting. Services shall be considered separate and 
distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care 
rendered in a nursing home.

1. Covered  
   a. Room and board in a semi-private room; general nursing care; medications, diagnostics 
      and special care units.
   b. The attending Practitioner’s services for professional care.
   c. Coverage is limited for Skilled Nursing Rehabilitative Facility Services. Skilled Nursing 
      Rehabilitative Facility services are limited to 100 days per Calendar Year following 
      approved hospitalization. The coverage limit is not applicable to chiropractic, cardiac, and 
      pulmonary rehabilitative services.

2. Exclusions  
   a. Custodial, domiciliary or private duty nursing services.
   b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.
   c. Services for cognitive rehabilitation.
   d. Services which were not authorized by the Plan.

M. Therapeutic/Rehabilitative Services  
Medically Necessary and Appropriate therapeutic and rehabilitative services intended to restore 
or improve bodily function lost as the result of illness or injury.

1. Covered  
   a. Outpatient, home health or office therapeutic and rehabilitative services which are 
      expected to result in significant and measurable improvement in the Member’s condition 
      resulting from an acute disease or injury. The services must be performed by, or under 
      the direct supervision of a licensed therapist.
   b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy; (3) 
      occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary 
      rehabilitative services.
      (1) Speech therapy by a licensed speech therapist is covered for restoration of speech 
      after a loss or impairment; and to initiate speech due to developmental delays (as 
      long as there is continued progress). The loss or impairment must not be caused by 
      mental, psychoneurotic or personality disorder.
   c. The services must be performed in a doctor’s office, outpatient facility or Home Health 
      setting. The limit on the number of visits for therapy applies to all visits for that therapy; 
      regardless of the place of service.
   d. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay 
      are covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility 
      section, and are not subject to the therapy visit limits.
   e. Coverage is limited for Speech, Physical, and Occupational Services. Speech, Physical, 
      and Occupational services are limited to 52 visits per therapy type per Calendar Year.

2. Exclusions  
   a. Treatment beyond what can reasonably be expected to significantly improve health, 
      including therapeutic treatments for ongoing maintenance or palliative care.
b. Enhancement therapy which is designed to improve the Member’s physical status beyond the pre-injury or pre-illness state.

c. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) vision exercise therapy; and (5) cognitive rehabilitation.

d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities which are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks which the Member can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services which can ordinarily be taught to the Member or a caregiver.

e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs.

f. Duplicate therapy. For example, when the Member receives both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

g. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit.

N. Organ Transplants

Medically Necessary and Appropriate services and supplies provided to the Member, when the Member is the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; (10) small bowel/liver; and certain bone marrow transplants. Transplant services or supplies that have not received Prior Authorization will not be covered. “Prior Authorization” is the pre-treatment authorization which must be obtained before any pre-transplant evaluation or any Covered Procedure is performed.

1. Prior Authorization Procedures

To obtain Prior Authorization, the patient or Practitioner must contact the Plan’s Transplant Case Management department before pre-transplant evaluation or transplant services are received. Authorization should be obtained as soon as possible after the patient has been identified as a possible candidate for transplant services. Transplant Case Management is a mandatory program for those Members seeking Transplant Services. Call the toll-free number on the front of the membership ID card for Member service and Transplant Case Management. We must be notified of the need for a transplant in order for it to be a Covered Service.

2. Covered Services

The following Medically Necessary and Appropriate transplant services and supplies, which have received Prior Authorization and are provided in connection with a covered procedure:

a. Medically Necessary and Appropriate services and supplies, otherwise covered under this program;

b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are covered only when Transplant Case Management approves a transplant

c. Travel expenses for the Member’s evaluation prior to a covered procedure, and to and from the site of a covered procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses and an approved companion

i. Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel for travel more than 30 miles away from the Member’s home to and from a facility in the In-Network Transplant Facility.

ii. Meals and lodging expenses are covered if Member or the Member’s companion travel more than 30 miles each way and are limited to $150 daily.

iii. The aggregate limit for travel expenses is $15,000 per covered procedure.

d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor’s compatibility; (2) removal of the organ from donor’s body; (3) preservation of the organ; and (4) transportation of the organ to the site of transplant.
Services are covered only to the extent not covered by other health coverage. The
search process and securing the organ are also covered under this benefit.
Complications of donor organ procurement are not covered. The cost of Donor Organ
Procurement is included in the total cost of the Organ Transplant.

3. Conditions/Limitations
The following limitations and/or conditions apply to services, supplies or charges:
   a. The Practitioner or the Member must notify Transplant Case Management prior to
      receiving any transplant service, including pre-transplant evaluation, and obtain prior
      authorization. If Transplant Case Management is not notified, the transplant and related
      procedures will not be covered;
   b. Transplant Case Management will coordinate all transplant services, including pre-
      transplant evaluation.
   c. Failure to notify of proposed transplant services, or to coordinate all transplant related
      services, will result in the reduction or exclusion of payment for those services;
   d. The Member must go through Transplant Case Management and receive prior
      authorization for transplant to be covered;
   e. Bone marrow transplantation will fall into one of three categories: syngeneic, allogeneic
      or autologous. Expenses eligible for coverage include the charge to harvest bone marrow
      for covered persons diagnosed with any covered malignant condition or any conditions
      approved for coverage by the claims administrator. Coverage for harvesting,
      procurement, and storage of stem cells, whether obtained from peripheral blood, cord
      blood, or bone marrow will be covered when re-infusion is scheduled within three months
      or less. Autologous bone marrow transplantation is considered investigational in the
      treatment of other malignancies, including primary intrinsic tumors of the brain.

4. Exclusions
The following services, supplies and charges are not covered under this section:
   a. If no prior authorization obtained, the transplant and related services will not be covered;
   b. Services or supplies not specified as Covered Services under this section;
   c. Any attempted covered procedure that was not performed, except where such failure is
      beyond the Member’s control;
   d. Non-Covered Services;
   e. Services which would be covered by any private or public research fund, regardless of
      whether the Member applied for or received amounts from such fund;
   f. Any non-human, artificial or mechanical organ;
   g. Payment to an organ donor or the donor’s family as compensation for an organ, or
      payment required to obtain written consent to donate an organ;
   h. Donor services including screening and assessment procedures which have not received
      prior authorization;
   i. Removal of an organ from a Member for purposes of transplantation into another person,
      except as covered by the Donor Organ Procurement provision as described above;
   j. Harvest, procurement, and storage of stem cells, whether obtained from peripheral
      blood, cord blood, or bone marrow when reinfusion is not scheduled within three (3)
      months of harvest
   k. Other non-organ transplants (e.g., cornea) are not covered under this Section, but may
      be covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically
      Necessary.

O. Dental Services
Note: This Plan does not cover basic dental services for CoverKids Members 19 years and over.
Please contact the dental service carrier for any questions related to basic dental services.
Medically Necessary and Appropriate services performed by a doctor of dental surgery (DDS), a
doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral surgery
except as indicated below.
1. Covered
   a. Dental services and oral surgical care resulting from an accidental injury to the jaw, sound
      natural teeth, mouth, or face, due to external trauma. The surgery and services
      must be started within 3 months and completed within 12 months of the accident.
b. Extraction of impacted wisdom teeth.

c. Orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function.

d. General anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure. This section does not provide coverage for the dental procedure other than those set forth in subsection a. above, just the related expenses. Prior Authorization is required. Coverage of general anesthesia, nursing and related hospital expenses is provided for the following:

1) Complex oral surgical procedures which have a high probability of complications due to the nature of the surgery;

2) Concomitant systemic disease for which the patient is under current medical management and which significantly increases the probability of complications;

3) Mental illness or behavioral condition which precludes dental surgery in the office;

4) Use of general anesthesia and the Member’s medical condition requires that such procedure be performed in a Hospital; or

5) Dental treatment or surgery performed on a Member eight (8) years of age or younger, where such procedure cannot be safely provided in a dental office setting.

2. Exclusions

a. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental X-rays; (6) fillings; (7) tooth extraction; (8) periodontal surgery; (9) prophylactic removal of teeth; (10) root canals; (11) preventive care (cleanings, X-rays); (12) replacement of teeth (including implants, false teeth, bridges); (13) bone grafts (alveolar surgery); (14) treatment of injuries caused by biting and chewing; (15) treatment of teeth roots; and (16) treatment of gums surrounding the teeth.

b. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints.

c. Dental procedures, except as otherwise indicated in the Member’s healthcare benefits plan.

P. Temporomandibular Joint Dysfunction (TMJ)

Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

1. Covered

a. Diagnosis and management of TMJ or TMD.

b. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.

c. Non-surgical TMJ includes: (1) history exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) appliances to stabilize jaw joint and (7) medications. Note: There is no coverage limit on Non-surgical treatment of TMJ or TMD.

d. Orthodontic treatment if medically necessary.

2. Exclusions

a. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of teeth; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

b. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

Q. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

1. Covered

a. Non-routine Diagnostic Services ordered by a Practitioner.

b. All other Diagnostic Services ordered by a Practitioner.

2. Exclusions

a. Diagnostic Services which are not Medically Necessary and Appropriate.

b. Diagnostic Services not ordered by a Practitioner.
R. Provider-Administered Specialty Drugs
Medically Necessary and Appropriate specialty pharmaceuticals for the treatment of disease, administered by a Practitioner or home health care agency.

Note: Cover Kids Members utilize the BCBST Provider-Administered Specialty Pharmacy Products List located on the Company website at http://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf. Please review the listing to determine which drugs may require Prior Authorization or have other limitations.

1. Covered
   a. Provider-administered Specialty Drugs as identified on the Provider-Administered Specialty Pharmacy Products List (includes administration by a qualified Provider).

2. Exclusions
   a. Self-administered Specialty Drugs.

S. Vision
Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries which impair vision. **Note:** This Plan does not cover routine vision services for pregnant women 19 years and over.

1. Covered
   a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
   b. First set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery.
   c. Rigid contact lenses and intrastromal corneal ring segments (ICRS) with diagnosis of keratoconus.
   d. One vision exam (including refractive exam and glaucoma testing) per Plan Year. Vision exam must be provided by a Network Provider.
   e. One set of lenses (including bi-focal, tri-focal, etc.) per Plan Year.
   f. Prescription contact lenses in lieu of eyeglasses.
   g. One set of eyeglass frames every 2 Plan Years.
   h. Approved optical services, supplies and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories participating in CoverKids. Prior approval is required for any other services or visual aids deemed to be necessary by recommendation of the Provider.

2. Exclusions
   a. Surgeries to correct refractive errors of the eyes.
   b. Eye exercises and/or therapy.
   c. Visual training
   d. Charges for vision testing exams, lenses, frames or contacts ordered while covered but not delivered within 60 days after coverage is terminated.
   e. Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowed for regular lenses.
   f. Charges filed for procedures the administrator determines to be special or unusual, such as orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, etc.
   g. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
   h. Charges in excess of the CoverKids Maximum Allowable Charge.

T. Durable Medical Equipment
Medically Necessary and Appropriate medical equipment or items which: (1) in the absence of illness or injury, are of no medical or other value to the Member; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not for the Member’s convenience. Some services require Prior Authorization.

1. Covered
   a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total CoverKids Maximum Allowable Charge for purchase. If the Member rents the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, the
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Member will be responsible for amounts in excess of the CoverKids Maximum Allowable Charge for purchase.

b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment.
c. Supplies and accessories necessary for the effective functioning of covered durable medical equipment.
d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging.

2. Exclusions
   a. Charges exceeding the total cost of the CoverKids Maximum Allowable Charge to purchase the equipment.
   b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment.
   c. Supplies and accessories that are not necessary for the effective functioning of the covered equipment.
   d. Items to replace those which were lost, damaged, stolen or prescribed as a result of new technology.
   e. Items which require or are dependent on alteration of home, workplace or transportation vehicle.
   f. Motorized scooters, exercise equipment, hot tubs, pool, saunas.
   g. “Deluxe” or “enhanced” equipment. The most basic equipment that will provide the needed medical care will determine the benefit.

U. Diabetes Treatment
Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment and supplies.

1. Covered
   a. Blood glucose monitors; Test strips for blood glucose monitors, as listed on the formulary.
   b. Insulin.
   c. Syringes.
   d. Lancets.
   e. Podiatric appliances for prevention of complications associated with diabetes.
   f. Medically Necessary routine foot care for individuals with a diagnosis of diabetes to include: diabetic shoes and inserts, nail clipping, and treatment for corns and calluses.
   g. Outpatient self-management training and education, including medical nutrition counseling. Available initially and when condition changes.
   h. Visual reading and urine test strips.
   i. Injection aids.
   j. Insulin pumps, infusion devices and appurtenances.
   k. Oral hypoglycemic agents.
   l. Glucagon emergency kits.

2. Exclusions
   a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

V. Prosthetics/Orthotics
Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb, which may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery. Some services require Prior Authorization.

1. Covered
   a. The initial purchase of surgically implanted prosthetic or orthotic devices.
   b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment.
   c. Splints and braces that are custom made or molded, and are incidental to a Practitioner’s services or on a Practitioner’s order.
d. The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging.

e. The initial purchase of artificial limbs or eyes,

f. The first pair of eyeglasses or contact lenses prescribed as a result of a cataract operation and obtained with 6 months following the surgery.

g. Cochlear Implantation – using FDA approved implants and provided all the following criteria are met:

For Children age 18
(1) Diagnosis of post-lingual profound deafness;
(2) Patient has achieved little or no benefit from a hearing aid;
(3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;
(4) Patient has cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and
(5) Patient has no contraindications to surgery.

For Children (Ages 2-17)
1) Diagnosis of bilateral profound sensorineural deafness; and
2) Patient has achieved little or no benefit from a hearing or vibrotactile aid, as demonstrated by the inability to improve on an age-appropriate closed-set word identification task.

An electrophysiological assessment should be performed to corroborate behavioral evaluation in very young children who cannot be adequately evaluated by standard audiology tests. This assessment may consist of an auditory brain stem evoked response or similar test which would be covered when Medically Necessary as determined by the claims administrator.

A minimum six-month trial with appropriate amplification (hearing aid or vibrotactile aid) and rehabilitation should be performed for children to ascertain the potential for aided benefit.

h. Foot orthotics are a covered expense for the following:

1) Therapeutic shoes if they are an integral part of a leg brace and are medically necessary, as determined by the claims administrator, for the proper functioning of the brace.
2) Therapeutic shoes, limited to one pair per Plan year (depth or custom -molded) including inserts and Medically Necessary modifications for Plan Members with diabetes mellitus and with any of the following complications:
   a) Peripheral neuropathy with evidence of callus formation; or
   b) History of pre-ulcerative calluses; or
   c) History of previous ulceration, or
   d) Foot deformity, or
   e) Previous amputation of the foot or part of the foot; or

i. Poor circulation. Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care

j. Prosthetic shoes, limited to one per lifetime, that are an integral part of prosthesis and Medically Necessary, as determined by the claims administrator, for Members with a partial foot

k. Ankle orthotics, foot orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses when medically necessary, as determined by the claims administrator.

l. Hearing aids. Limited to 1 per year per Calendar Year up to age 5; then 1 per ear every 2 years thereafter.

2. Exclusions

a. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.

b. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
c. The replacements of contact lenses after the initial pair have been provided following cataract surgery.

W. Home Health Care Services
Medically Necessary and Appropriate services and supplies provided in the Member’s home by a Practitioner who is primarily engaged in providing home healthcare services.

1. Covered
   a. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse.
   b. Home infusion therapy.
   c. Coverage is limited for Home Health services. Home Health Nursing services are limited to 125 visits per Calendar Year for care given or supervised by a registered nurse.

2. Exclusions
   a. Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (10) convenience items.
   b. Custodial, domiciliary or private duty nursing services.
   c. Medical social services.
   d. Dietary guidance.
   e. Services that were not Authorized by the Plan.

X. Hospice
Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less.

1. Covered
   a. Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

2. Exclusions
   a. Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.

Y. Supplies
Those Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury. Note: Supplies are limited to 31-day supply per Calendar Year.

1. Covered
   a. Supplies for the treatment of disease or injury used in a Practitioner’s office, outpatient facility or inpatient facility.
   b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner’s prescription.

2. Exclusions
   a. Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include but are not limited to: (1) band-aids; (2) dressing material for home use; (3) antiseptics; (4) medicated creams and ointments; (5) Q-tips; (6) eyewash; and (7) diapers.
   b. Supplies used in the home setting or otherwise for self-use, unless prescribed by a Practitioner and are both Medically Necessary and Appropriate.

Z. Prescription Drug Program
Benefits are provided for formulary prescription drugs and insulin prescribed when the Member is not confined in a hospital or other facility. Check the CoverKids Preferred Formulary Guidebook at http://bluecare.bcbst.com/forms/CKIDS_2018_Preferred_Formulary.pdf for the list of Prescription Drugs covered by the Pharmacy program.
Benefits are limited to a 30-day supply when purchased at a retail pharmacy. Some medications can be purchased up to a 90-day supply through home delivery or certain retail pharmacies. Some products may be subject to additional Quantity Limitations as adopted by the plan. The prescribing Provider will allow for substitution with a Generic Drug for a Preferred or Non-preferred Brand Name Drug (when available) under all circumstances, unless the prescribing Provider determines medical necessity of a Brand Name Drug (Preferred or Non-preferred) due to:

a. The Member previously experienced an adverse reaction to the Generic Drug;
b. The Generic Drug has been demonstrated to be ineffective for the Member; or
c. Any other clinically based need determined by the prescribing Provider.

If the Member chooses a Brand Name Drug (Preferred or Non-preferred) when a Generic Drug equivalent is available, the Member will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug copayment.

If the Member has a prescription filled at an Out-of-Network Pharmacy, that prescription will not be covered under this plan.

1. Covered Services
   a. Prescription Drugs prescribed when the Member is not confined in a hospital or other facility. Prescription Drugs must be:
      (1) prescribed on or after coverage begins;
      (2) approved for use by the Food and Drug Administration (FDA);
      (3) dispensed by a licensed pharmacist or Participating Physician;
      (4) listed on the Drug Formulary; and
      (5) not available for purchase without a Prescription.

2. Limitations
   a. Refills must be dispensed pursuant to a prescription. If the number of refills is not specified in the prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
   b. The Plan has time limits on how soon a prescription can be refilled. If the Member requests a refill too soon, the Network Pharmacy will advise the Member when the prescription benefit will cover the refill.
   c. Prescription and non-prescription medical supplies, devices and appliances are not covered, except for syringes or other supplies used in the treatment of diabetes;
   d. Prescription Drugs which are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA approved dosage for four calendar weeks.
   e. The Plan does not cover Prescription Drugs prescribed for purposes other than for:
      1) indications approved by the FDA; or
      2) off-label indications recognized through peer-reviewed medical literature.
   f. Compound Drugs are excluded from coverage unless BlueCare Tennessee determines the compound to be Medically Necessary and Medically Appropriate. If approved, Compound Drugs are only covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the pharmacy benefit manager. All ingredients in a compound medication must be covered for the system to process. If any ingredient is non-covered, the claim will deny. Bulk powders and select bulk chemicals will not be Covered.
   g. Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:
      (1) Prescription must be written by a licensed Physician;
      (2) Prescriptions are for a 90-day period only; and
      (3) Benefit is allowable once per Plan year, with a maximum lifetime benefit of two 90-day periods.
3. Exclusions
   The following services, supplies and Charges are not covered under this section:
   a. drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility, except as otherwise covered in the Member Handbook;
   b. any drugs, medications, prescription devices or vitamins, available over-the-counter that do not require a prescription by federal or state law; and/or prescription drugs dispensed in a doctor’s office are excluded except as otherwise covered in this Member Handbook;
   c. any quantity of prescription drugs which exceed that specified by the Plan’s P&T Committee;
   d. any prescription drug purchased outside the United States, except those authorized by us;
   e. any prescription dispensed by or through a non-retail internet Pharmacy;
   f. non-medical supplies or substances, including support garments, regardless of their intended use;
   g. any drugs or medicines dispensed more than one year following the date of the prescription;
   h. Prescription drugs the Member is entitled to receive without charge in accordance with any worker’s compensation laws or any municipal, state, or federal program;
   i. replacement prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
   j. drugs dispensed by a Provider other than a Pharmacy;
   k. administration or injection of any drugs;
   l. Prescription drugs not on the Drug Formulary;
   m. Prescription drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
   n. DESI (Drug Efficiency Safety Implementation) and LTE (Less Than Effective) Drugs;
   o. Experimental and/or Investigational Drugs;
   p. Prescription drugs obtained from an Out-of-Network Pharmacy;
   q. Provider-Administered Specialty Drugs, as indicated on BCBST Specialty Drug List, except as otherwise covered in the Member Handbook.
   r. Prescription Drugs or refills dispensed:
      1) in quantities in excess of amounts specified in the Benefit payment section; or
      2) which exceed any applicable maximum benefit amounts stated in the Member Handbook.

   The Plan will retain any refunds, reimbursements or other payments representing a return of monies paid for Covered Services under this section.

BENEFITS FOR SELF-ADMINISTERED SPECIALTY DRUGS
   There is a distinct network for Provider-administered Specialty Drugs: the Specialty Pharmacy Network. The Member will receive the highest level of benefits when they use a specialty pharmacy Network Provider for self-administered Specialty Drugs. Specialty Pharmacy Drugs are limited to a 30-day supply per prescription. A listing of Self-Administered Specialty Pharmacy Drugs can be found at https://www.bcbst.com/docs/providers/RX-11-2018-Preferred_Formulary_and_Prescription_Drug_List_Web.pdf.

EXCLUSIONS FROM COVERAGE
   CoverKids does not provide benefits for the following services, supplies or charges:
   1. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by the Plan.
   2. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
   3. When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet the Member’s needs, we reserve the right to provide payment for the least expensive Covered Service alternative.
   4. Self-treatment or training.

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5. Staff consultations required by hospital or other facility rules.
6. Services which are free.
7. Services or supplies for the treatment of illness or injury related to the Member's participation in a felony, attempted felony, riot or insurrection.
8. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage.
9. Personal, physical fitness, recreational or convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds, (13) weight loss programs; (14) physical fitness programs; (15) diapers; or (16) self-help devices which are not primarily medical in nature, even if ordered by a Practitioner.
10. Services or supplies received before the Member's effective date for Coverage with this Plan.
11. Services or supplies related to a Hospital Confinement, received before the Member's effective date for Coverage with this Plan.
12. Services or supplies received after the Member's Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while the Member was Covered.
13. Services or supplies received in a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union or similar group.
14. Telephone or email consultations or charges to complete a claim form or to provide medical records. Network Providers should not bill the Member for missed appointments nor are the charges for missed appointments Covered.
15. Services for providing requested medical information or completing forms. The plan will not charge the Member or their legal representative for statutorily required copying charges.
16. Court ordered examinations and treatment, unless Medically Necessary.
17. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
18. Charges in excess of the CoverKids Maximum Allowable Charge for Covered Services or any charges which exceed the individual benefit limits.
19. Any service stated in the Member Handbook as a non-Covered Service or limitation.
20. Charges for services performed by the Member or their spouse, or the Member’s or their spouse’s parent, sister, brother or child.
21. Any charges for handling fees.
22. Safety items, or items to affect performance primarily in sports-related activities.
23. Services or supplies related to treatment of complications that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating Physician.
24. Services or supplies related to cosmetic services, including surgical or other services, drugs or devices. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) rhinoplasty; (7) breast augmentation; and (8) breast reduction. This exclusion will not apply to the following conditions:

CoverKids does not provide benefits for the following services, supplies or charges:
(a) The covered person experienced a traumatic injury or illness, which requires cosmetic surgery;
(b) It is for treatment of a congenital anomaly which severely impairs the function of a bodily organ in a covered person;
(c) If elected by the covered person following a mastectomy, as specified in the Member Handbook, Covered Services:
(d) Breast implant removal and breast capsulectomy with reconstruction when Physician documented symptoms of pain, discomfort or deformity related to breast implants or capsule contracture is present.
25. Blepharoplasty and browplasty, except for: (1) correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies); (2) treatment of edema and irritation resulting from Grave's disease; or (3) correction of trichiasis, ectropion, or entropion of the eyelids.


27. Services or supplies for orthognathic surgery.

28. Services or supplies for Maintenance Care.

29. Private duty nursing that would normally be provided by nursing staff, including private duty nursing care in a facility.

30. Pharmacogenetic testing.

31. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.

32. Services or supplies for methadone maintenance therapy.

33. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.

34. Services or supplies for Inmates confined in a local, state or federal prison or jail, or other penal correctional facility, including a furlough from such facility.

F. Reimbursement Methodology

Final reimbursement determinations for CoverKids are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member copayments, benefit plan exclusions/limitations, authorizations/referral requirements and Medical policy. Effective 1/1/2016, the reimbursement rate for care provided to CoverKids Members increased by 3.2 percent.

Note: See Section V. Billing and Reimbursement in this Manual for specific billing and reimbursement guidelines.

G. Utilization Management

The CoverKids Utilization Management (UM) Program is intended to assure the provision of appropriate health care to all CoverKids Members in the most cost-effective manner. The following services require prior authorization for CoverKids Members.

- All non-covered, investigational or cosmetic procedures or services, maybe covered based on Medical Necessity
- All out-of-network services(hospital or professional) unless Emergency services (based on diagnosis code filed on claim)
- All transplants
- All Inpatient hospital admissions except for delivery admissions

Outpatient Services

The following outpatient services require an authorization:

- Arthroscopy
- Endoscopy
- Laparoscopic Cholecystectomy
- Nerve Conduction Studies
- Epidural steroid Injections
- All services performed by a plastic specialist, including but not limited to:
  - Abdominoplasty/Panniculectomy
  - Blepharoplasty
  - Breast Reduction
  - Reconstructive Repair Pectus Excavatum
  - Vein Ligation
Specialty Pharmacy
Certain high risk/high-cost specialty pharmacy medications administered in any setting other than inpatient. This authorization requirement applies to all Provider types including home infusion therapy Providers and hospitals providing outpatient infusions and injections.

Durable Medical Equipment (DME)
The following services require an authorization unless listed on the DME no prior authorization required code description list found on the BlueCare Tennessee website at http://bluecare.bcbst.com.

- All Durable Medical Equipment services supplied by a DME Provider
- All Orthotics and Prosthetics provided by an O&P Provider
- All DME Repairs serviced or supplied by a DME Provider

Behavioral Health Services (BHO)
The following BHO services require a prior authorization.
- Inpatient
- Subacute
- Residential Treatment
- Detoxification
- Psychiatric Partial Hospitalization Program (PHP)
- Psychiatric Intensive Outpatient Program (IOP)
- Crisis Stabilization (Notification Only)
- Electro-Convulsive Therapy (ECT)
- Psychological Testing
- 23-Hour Bed
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analyst (ABA) Services
- Comprehensive Child and Family Treatment (CCFT)
- Continuous Treatment Team (CTT)

Home Health Services
- All Home Health Services require Prior Authorization

H. Contact Us

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Service</td>
<td>1-888-325-8386</td>
</tr>
<tr>
<td>Provider Service</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>Prior Authorization for Medical and Behavioral Health</td>
<td>1-800-924-7141</td>
</tr>
<tr>
<td>Fax</td>
<td>1-800-851-2491</td>
</tr>
<tr>
<td>Case Management</td>
<td>1-800-225-8698</td>
</tr>
<tr>
<td>Transplant Case Management</td>
<td>1-800-225-8698</td>
</tr>
<tr>
<td>Disease Management</td>
<td>1-888-416-3025</td>
</tr>
<tr>
<td>Nurse Advice Line</td>
<td>1-866-904-7477</td>
</tr>
</tbody>
</table>
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XIX. Provider Audit Guidelines

A. Overview

All claims submitted to BlueCare Tennessee and any of its affiliates and/or subsidiaries for reimbursement are subject to audit for the purpose of verifying the information submitted is correct, complete, in accordance with Provider contract requirements, and supported by established coding guidelines.

Claims are routinely analyzed for potential billing and coding irregularities, as well as known areas of potential fraud and abuse. Audit of specific Providers or Provider groups may also be requested by any vested party.

All records requested must be provided; claims payments involved with records not received are subject to immediate recovery as unsubstantiated by documentation.

Audits are based on recognized coding and billing guidelines such as, but not limited to the UB Coding Editor, ICD Manuals and CPT® Manual as well as specific Provider contractual language, Medical Policy and Medical Necessity review.

Audit rights are defined in this Manual and in the Provider Agreement and Contractor Risk Agreement with the State of Tennessee. Claims found with errors, both overcharges and undercharges, will be submitted for adjustment.

B. Audit Process

Audit Scheduling
All Providers are given advance notice of scheduled audit dates. Once an audit is scheduled, it should not be changed or cancelled except for extenuating circumstances. If scheduled audits are continually delayed, or denied by the Provider, payment for those claims selected for audit will be retracted until the audit is allowed.

Medical Record Request Process
When requested by BlueCare Tennessee or a designated vendor, Provider will be required to furnish in a timely manner medical records and encounter data in electronic or hardcopy format. Medical records may be submitted via our secure file transfer portal (SFTP) that is fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and requires minimal set up. All complete medical records must be provided by the beginning of the audit to help ensure a timely audit schedule. Any additional documentation requested during the audit must be provided timely. Medical records not provided at the audit start date may result in retraction of payment.

All medical records must be provided (electronic or hardcopy) to BlueCare Tennessee to support audit findings for the Division of TennCare, whether the audit is conducted onsite or via remote access to the facility’s medical record system. Electronic Health Records (EHR) records must contain a system generated permanent date and time record for all entries as required by HIPAA.

Audit Process
All claims are reviewed for correct coding and billing, contract compliance and accurate reimbursement based on applicable regulatory governing agencies and BlueCare Tennessee guidelines as published in this Manual, Medical Policies, and Medical Necessity.

Facility Audit Process
Facility Audit schedules audits in advance and medical records are requested a minimum of eight (8) weeks before the scheduled audit date. This provides ample time to compile and submit medical records,
I-bills and invoices, and ER tools, as applicable. Audits begin on the scheduled date and it is expected that all documentation has been received prior to the actual start date of the audit. Audit staff will be available daily during the audit period to discuss audit concerns and findings and will conduct an exit interview with designated staff at the conclusion of the audit to provide a general overview of all audit outcomes. Facilities should not file corrected claims for issues identified during audit, unless instructed to do so by the auditors. Corrections/changes to claims audited should be handled via reconsideration/appeal process as advised during the audit.

Audit Accommodations
BlueCare Tennessee reserves the right to conduct on-site audits; however, most audits are conducted by electronic medical record review. If onsite audit is scheduled, adequate and reasonable accommodations will be required during the audit. These accommodations include but are not limited to adequate desk space, location compatible for wireless internet service, lighting, environment with minimal noise or distraction for the auditors, temperature, seating, etc. A single location for the entire audit team without relocation during the audit is expected.

If auditors are expected to connect to the Provider’s system for access to medical records, Providers are responsible for ensuring connectivity, communicating instructions, and providing training on computer systems prior to the audit. E-mail communications outline the requirements for remote access given to auditors, but the testing process and validation of access is expected two weeks prior to begin date of the scheduled audit.

Audit Findings
The Provider will receive a Final Audit Report detailing the results of each audited claim at the audit conclusion, normally within thirty (30) days. The claims found in error may be submitted for adjustment and/or re-adjudication. Providers are expected to correct identified issues immediately.

Subsequent Audits
A decision may be made to expand the audit scope based on audit findings.

Additional follow-up audits may be performed to substantiate the Provider has made any necessary corrections to billing and/or documentation practices according to the billing and coding guidelines cited on a previous audit.

Vendor Audits
BlueCare Tennessee, or a vendor designated by us, is allowed to perform on-site, desk, or remote audits and inspections of financial and/or medical records, and Utilization Management covering treatment of any BlueCare Tennessee Member. Such audits and inspections shall be permitted without charge to us or its designated vendor, who shall be provided copies of records involving the audit or inspection without charge.

BlueCare Tennessee has contracted with claim audit vendors to perform pre and post payment coding, utilization and Medical Necessity audits. BlueCare Tennessee’s claim audit vendors follow CMS auditing procedures similar to those practiced by the Medicare claims audit vendor where Clinical Review Judgment (CRJ) is used to determine if the services provided were Medically Necessary, coded at the appropriate level and/or billed according to recognized utilization standards. CRJ is utilized on all complex audits and involves a thorough review of all submitted medical documentation in order for the reviewer to develop a complete clinical picture of the patient as part of the evaluation. In addition to the complex reviews, BlueCare Tennessee’s claims audit vendors also perform automated audits utilizing proprietary algorithms to identify potential overpayments as a result of billing and coding errors.

Submission of Outpatient Claims Following an Audit
In accordance with CMS ruling 1455-R issued on March 13, 2013, BlueCare Tennessee will accept outpatient claims from facilities for the outpatient services (emergency room visits, observation services, etc.) performed prior to an inpatient admission when our recovery audit vendor has determined that the inpatient admission was not Medically Necessary. BlueCare Tennessee will process the outpatient claims according to our normal processing and reimbursement rules.
BlueCare Tennessee  
Provider Administration Manual

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it is the 
result of a vendor audit, and submit it within 120 days of the date of our remittance advice reflecting 
recovery of the inpatient claim. If a facility has appealed an audit decision and received a denial, the 
outpatient claim should be submitted within 120 days of the date of the appeal decision. A copy of the 
appeal decision should also be submitted to help ensure proper handling of the claim. Additionally, 
hospitals must maintain documentation to support the services billed on the outpatient claim.

C. Operational Guidelines for Facility Emergency Department Claims
Audit Process

Step 1: For all lines of business, effective April 1, 2012, BlueCare Tennessee will conduct ED audits 
utilizing the hospital’s current designated ED claims level classification tool.

Step 2: The facility, within two (2) weeks notification of the audit, will send BlueCare Tennessee an 
electronic or hardcopy version of their facility’s current ED classification tool(s), the effective dates of the 
tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the 
tool(s).

Step 3: If the facility has changed ED tool or modified the logic in its current ED classification 
tool during the audit period, we reserve the option to use the hospital’s previous ED classification tool 
version upon an observed shift increase of 5 percent or more of ED levels 4 and/or 5.

Step 4: The baseline will be established by a comparison of the ED claims billed prior to ED classification 
tool logic modification or complete tool change against the ED claims billed using 
the modified version (see illustration below).

- Based upon the ED tool modification date, BlueCare Tennessee will include six (6) months 
  retrospective claims data during the analysis of the previous ED tool.
If the facility has changed ED tool or modified the logic in its current ED classification tool within 
three (3) months from the end of the audit period, we will perform the audit using both tools 
as indicated by the effective dates of the tool(s).

<table>
<thead>
<tr>
<th>Example: Determining if analysis is needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Date: Apr-12</td>
</tr>
<tr>
<td>Claim Date Range: Dec-10 thru Jan-12</td>
</tr>
<tr>
<td>Audit Tool Modified: Jun-11</td>
</tr>
</tbody>
</table>
| Comparison: Dec-10 thru May-11 Audit period using previous ED tool (6 months)
  Jun-11 thru Jan-12 Audit period using modified ED tool (3 months or greater)

<table>
<thead>
<tr>
<th>Example: Analysis in determining 5% increase</th>
</tr>
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<tbody>
<tr>
<td>ED Levels</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>L1</td>
</tr>
<tr>
<td>L2</td>
</tr>
<tr>
<td>L3</td>
</tr>
<tr>
<td>L4</td>
</tr>
<tr>
<td>L5</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Step 5: BlueCare Tennessee will notify the facility of the observed shift increase of five (5) 
percent or more of ED levels 4 and/or 5 and the intent to audit with previous classification tool for 
all ED claims in the audit OR the intent to audit using two (2) tools as indicated by the effective 
dates of the tool(s).

Step 6: BlueCare Tennessee will perform the audit and communicate findings as usual.
Any facility that outsources ED coding to a 3rd party vendor is still obligated to provide an electronic or hardcopy version of their facility’s current ED classification tool(s), the effective dates of the tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the tool(s). In the event the facility or 3rd party vendor does not provide the above-referenced information with the timeframe established by Step 2. BlueCare Tennessee reserves the right to conduct ED audits utilizing the following Emergency Room Level Determination audit tool:

### Emergency Room Level Determination

**Instructions:** Circle the documented interventions in each level. Assign the highest level that meets the criteria listed.

**Diagnosis:**

<table>
<thead>
<tr>
<th>Level/CPT®</th>
<th>Possible Interventions</th>
</tr>
</thead>
</table>
| 99281 1 Intervention Present | • VS x 1 – (PR and BP)  
• A completed clinical assessment form  
• Instructions for specimen collection  
• OTC meds administered  
• Uncomplicated suture removal  
• Simple dressing change  
• Immunization |
| 99282 Requires 2 or more of these Interventions | • VS x 1 – (PR and BP)  
• O2 Sat x 1  
• Neuro Check x 1  
• Administer prescription drug, PO, topical  
• Assessment fetal heart tones  
• Assisting MD with any exam  
• Basic specimen testing: Accuchek, dipstick, UA clean catch  
• Complicated or infected suture removal  
• Enema or disimpaction  
• Simple cultures (throat, skin, urine, wound)  
• Simple laceration/abrasion repair (w/Dermabond, w/o sutures)  
• Simple removal of FB without incision or anesthetic  
• Venipuncture for lab  
• Visual acuity exam |
| 99283 Requires 3 or more of these Interventions | • VS x 2 – (PR and BP)  
• O2 Sat x 2  
• Neuro checks x 2  
• Accuchek x 2  
• Perform or assist w/ minor procedures: suturing, packing, I&D, casting, pelvic procedures beyond routine exam, Foley cath or irrig  
• Control of nasal hemorrhage  
• Doppler assessment  
• Ear or Eye irrigation  
• EKG x 1  
• IM/SQ med administered x 1  
• INT insertion  
• IV fluids w/o meds  
• IV push 1-2  
• Nasopharyngeal suctioning  
• Nebulizer treatment x 1  
• Oxygen therapy  
• Routine trach care (clean, change dressing, suction)  
• Telemetry  
• X-Ray x 1  
• Access Port |
# Emergency Room Level Determination (cont’d)

<table>
<thead>
<tr>
<th>Level/CPT®</th>
<th>Possible Interventions</th>
</tr>
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<tbody>
<tr>
<td>99284</td>
<td></td>
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</tbody>
</table>
| Requires 3 or more of these interventions. | - VS x 3 – (PR and BP)  
- O2 Sat x 3  
- Neuro checks x 3  
- Accuchek x 3  
- Blood or blood products administered x 1 unit  
- Change trach tube  
- Coordination for admission or observation to any facility  
- EKG – 2 or more  
- IM/SQ med administered x 2  
- IV med drip  
- IV push x 3 – 4  
- Insertion nasal/oral airway  
- Insertion PEG or NG tube  
- Care of confused, combative pt or change in mental status  
- Nebulizer treatment x 2  
- Nonconfirmed overdose  
- PICC insertion  
- Use of specialized resources – SS, hearing, visual impairment, police, crisis management.  
- Radiological testing of 2 – 3 areas |
| 99285      |                         |
| Requires 3 or more of these interventions. | - VS x 4 or more – (PR and BP)  
- O2 Sat x 4  
- Neuro cks x 4  
- Accucheks x 4  
- Assisting w/ major procedure: FX reduction/ relocation, endotracheal/ trach tube insertion, endoscopy, thoracentesis, paracentesis, LP, conscious sedation  
- Decontamination for isolation, hazardous material  
- IV med administered requiring intensive monitoring  
- IV push x 5 or more  
- Multiple (2 or more) IV lines infusing  
- Nebulizer treatment x 3  
- Precipitous delivery in ER  
- Use of chemical or physical restraints  
- Radiological testing of 4 or more areas |
| 99291      |                         |
| Critical Care – Requires both criteria | - Time 30 – 74 minutes  
- Critical Condition  
- Additional Notes |
| 99292      |                         |
| Critical Care – Requires both criteria | - Time 75 – 104 minutes  
- Critical Condition  
- Additional Notes |

**NOTES:**

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D. Data Mining and Claims Auditing

Claims Data Analysis is performed using algorithms that analyze claims data prospectively and retrospectively. Claims are evaluated, both individually and against other claims utilizing edits developed from recognized standards of coding, billing and reimbursement. Claims will be adjusted according to the results of the application of these principles. BlueCare Tennessee and any of its affiliates and/or subsidiaries reserve the right to periodically evaluate and modify these edits.

E. Reconsideration Process

In the event you wish to dispute Provider Audit findings, you may submit a written request for reconsideration and state why you disagree. Additional supporting documentation and medical records applicable to your dispute should be included. Claims audited are subject to the Provider Dispute Resolution Process. See Section XII. Provider Dispute Resolution Procedure in this Manual for detailed information.
XX. TennCare Kids

A. TennCare Kids Services – (Does not apply to CoverKids)

The TennCare Kids Program is a full program of checkups and health care services for children from birth to under age 21 years who have TennCare. These services make sure that babies, children, teens and young adults receive the health care they need.

The TennCare Kids Program requires Providers to refer Members under age 21 for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects and mental illnesses and conditions discovered by the screening services, regardless of whether the required services are covered by BlueCare Tennessee. Every Member under the age of 21 years should receive checkups, even if there is no apparent health problem. No prior authorization is required. Pursuant to 42 USC § 1396d(r), TennCare Kids services shall at a minimum include:

1. **Screening services provided at intervals:**
   a. which meet reasonable standards of medical, behavioral and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care;
   b. indicated as Medically Necessary, to determine the existence of certain physical or mental illnesses or conditions.

2. **Services which, at a minimum, include:**
   a. comprehensive health and development history (including assessment of both physical and mental health development and dietary practices);
   b. a comprehensive unclothed physical exam (the child’s growth, including measurements, shall be compared against that considered normal for the child’s age and gender);
   c. appropriate immunizations schedule according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history (see Section XIV. Preventive Care in this Manual for Recommended Immunization Schedule). The ACIP Recommendations on Immunization Practices are approved by the American Academy of Pediatrics;
   d. laboratory tests (including Lead Toxicity Screening appropriate for age and risk factors). All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood test at age 12 months and 24 months. Risk assessments are to be performed with appropriate action to follow if equal to or greater than five (5) ug/dL at ages 6 months, 9 months, 18 months, and 3 to 6 years; and
   e. health education including anticipatory guidance based on the findings of the physical and/or dental screening. Health education should include counseling to both parents (guardians) and children to assist in understanding what to expect in terms of the child’s development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

3. **Vision services**
   a. which are provided at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care;
   b. which at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.
4. **Dental services which are provided**
   a. at intervals which meet reasonable standards of dental practice as determined by the state after consultation with recognized dental organizations involved in child health care and
   b. at such other intervals, indicated as Medically Necessary, to determine the existence of a suspected illness or condition,
   c. which shall at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health; and
   d. which shall encourage Providers to refer children to dentists for preventive dental care and screening in accordance with the dental periodicity schedule, and as otherwise appropriate.

5. **Hearing services which are provided**:
   a. at intervals which meet reasonable standards of medical practice as determined by the state after consultation with recognized medical organizations involved in child health care and
   b. at such other intervals, indicated as Medically Necessary, to determine the existence of a suspected illness or condition and
   c. which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

6. **Transportation assistance** for a child includes related travel expenses, cost of meals, and lodging in route to and from care, and the cost of an attendant to accompany a child if necessary. Blanket restrictions may not be imposed when determining coverage for transportation services. Each determination shall be based on individualized circumstances for each case and documented by BlueCare Tennessee and/or the Transportation Vendor.

   The requirement to provide cost of meals shall not be interpreted to mean that an Enrollee and/or an attendant can request meals while in transport to and from care. Rather, this provision is intended for use when an Enrollee has to be transported to a major health facility for services and care cannot be completed in one day thereby requiring an overnight stay.

   BlueCare Tennessee shall offer transportation and scheduling assistance to all children under age 21 who do not have access to transportation in order to access covered services. This may be accomplished through various means of communication to Enrollees, including but not limited to, Member handbooks, TennCare Kids outreach notifications, etc.

   Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to Member’s age, or lack of accompanying adult. Any decision to deny transportation of a minor child due to a Member’s age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the “mature minor exception” to permission for medical treatment.


   The *State Medicaid Manual* currently says that children with elevated blood lead levels should be followed according to CDC guidelines. 2012 CDC guidelines include follow up blood tests and investigations to determine the source of lead, when indicated for blood lead levels equal to or greater than five (5) ug/dL.
BlueCare Tennessee Care Coordination will provide any follow up service including monitoring and documenting elevated blood lead levels (EBLLs), assisting with coordination of Medically Necessary services, and coordinating the primary environmental lead investigation to determine the source of lead for children when elevated blood levels suggest a need for such investigation. This investigation, which is commonly called a “lead inspection”, involves the use of X-ray fluorescence (XRF) machines in the home which have the ability to identify lead-based paint.

If the lead inspection does not reveal the presence of lead paint in the home, there may be a need for other testing, such as “risk assessments” involving water and soil sampling or inspections of sites other than the primary residence if the child spends a substantial amount of time in another location. BlueCare Tennessee is not responsible for either the “risk assessments” or the lead inspection at the secondary site. The Tennessee Department of Health (TDH) will be contacted when these services are indicated. TDH has a federal grant, which can be used to purchase such services when either or both are deemed necessary by health department staff, as long as funds are available. The assessments are performed by certified inspectors in the Tennessee Department of Environment and Conservation (TDEC).

MCO reimbursement for the primary environmental investigation is limited to the items specified in Part 5 of the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual. These items include the health professional’s time and activities during the on-site investigation of the child’s primary residence. They do not include testing of environmental substances such as water, paint, or soil.

8. Such other necessary health care, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) (Section 1905(a) of the Social Security Act) to correct, ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Screening Definition/Requirement
42 CFR 441.56(b) defines “screening” as “periodic comprehensive child health assessments” meaning “regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth”. At a minimum, screenings must include, but are not limited to:

1. Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
2. Comprehensive unclothed physical examination including measurements (the child’s growth shall be compared against that considered normal for the child’s age and gender);
3. Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;
4. Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as Medically Necessary to determine the existence of suspected illness or condition;
5. Appropriate laboratory tests (including lead toxicity screening for age and risk factors). All children are considered at risk and shall be screened for lead poisoning; and
6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
7. Health education which includes anticipatory guidance.

Pursuant to the TennCare/MCO Contractor Risk Agreement (CRA), Section 2.7.6.3.2, “At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral, and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined the ‘reasonable standards of medical and dental practice’ are those standards set forth in
the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare website. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings."

Should screenings indicate a need, the following services must be provided, even if the services are not included in the State plan:

1. Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;
2. Dental care services furnished by direct referral to a dentist, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health;
3. Referral assistance as required by 42 CFR 441.61, including referral to Providers and State health agencies. All referrals must be documented in the Enrollee’s medical record; and
4. Such other necessary healthcare, diagnostic services, treatment, and other measures described in 42 USC 1396d(a) to correct or ameliorate or prevent from worsening defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.
5. No prior authorization or written primary care Provider (PCP) referral is needed in order for a Member to obtain a mental health or substance use assessment, whether the assessment is requested as follow-up to a TennCare Kids screening or an interperiodic screening.

In the event a screening reveals the need for other health care and the Provider is unable to make an appropriate referral for those services, the Provider must notify the Enrollee’s MCO for assistance in securing the appropriate referral.

Practitioners and other healthcare Providers may wish to document services provided to BlueCare and TennCareSelect children under age 21 years by using the Pediatric Initial Health Assessment form. The Pediatric Initial Health Assessment form in English and Spanish is located on the BlueCare Tennessee website at https://bluecare.bcbst.com/providers/forms.html.

Note: Pursuant to requirements outlined in the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual, Part 5, Section 5310A, Providers are required to have a process for documenting services declined by a parent or guardian or mature competent child specifying the particular TennCare Kids service declined. Additionally, Providers are required to have a process for adults specifying the particular service declined.
B. TennCare Kids Screening Guidelines

Every child under the age of 21 years is eligible for TennCare Kids services and should receive checkups, even if there is no apparent health problem.

After a child reaches school age, it is an enormous challenge to get parents to make appointments for routine well care. As a health care Provider who cares for these children when they are ill, our Members trust you to direct them in their health care needs. Providers should review the medical history for each Member under the age of 21 to determine if he/she is due for a TennCare Kids screening while he/she is in your office for acute care, or sports/camp physicals, regardless of whether the Member is assigned to you or another PCP in your group, or a covering Provider. TennCare Kids services should be provided and documented during the office visit as appropriate for age and condition, and a follow-up visit scheduled if necessary to complete all required components of the TennCare Kids examination or to further address concerns or questions remaining from the examination.

1. Hearing and Vision Screenings for Members Under 21 Years Old
   The American Academy of Pediatrics (AAP) recommends every infant have a newborn Preventive Pediatric Health Care evaluation after birth and a 30-month early childhood preventive visit. Routine hearing and vision screening should be included in every preventive visit for BlueCare and TennCareSelect Members under age 21 in accordance with AAP periodicity guidelines. A comprehensive periodicity schedule that includes, but is not limited to age/risk appropriate recommendations for Measurements (including BMI assessment), Sensory screenings, Procedures, and Developmental/Behavioral assessments is available for viewing, printing or ordering at http://brightfutures.aap.org/tool_and_resource_kit.html.

2. Developmental, Emotional/Behavioral and Elevated Blood Lead Level Screenings
   The following pages offer developmental, emotional/behavioral and elevated blood lead level screening tools recommended for use in TennCare Kids screenings:
Documentation should include a description of the developmental behavioral screening method. The following items should be documented in the medical record when developmental/behavioral screening is done during a TennCare Kids encounter:

- Any parental concerns about the child’s development/behavior.
- A review of major age-appropriate areas of development/behavior (e.g., motor, language, social, adaptive).
- An overall assessment of development/behavior for age (e.g., normal, abnormal, needs further evaluation).
- A plan for referral and/or further evaluation when indicated.

The following list includes examples of developmental/behavioral screening tests approved by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Guidelines Committee for use in the TennCare Kids Program. They have been approved and validated and used nationally. Providers who use alternative instruments should make a selection based on a similar standard of practice. These guidelines are subject to update and revision as needed. The listing also includes a specialized screen for maternal post-partum depression. Assessment for this condition should be made in the first weeks after birth and appropriate referral initiated as needed.

### Parental Postpartum Depression

<table>
<thead>
<tr>
<th>Name of Screen</th>
<th>Age Range for Screen</th>
<th>Description</th>
<th>Scoring</th>
<th>Accuracy</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Edinburg Postnatal Depression Scale (EPDS)</strong></td>
<td>6 – 8 Weeks postnatal</td>
<td>Developed to assist primary care health professionals to detect mothers suffering from postnatal depression. Scale consists of ten items and indicates how the mother has been feeling during the previous week; it may be usefully repeated after two weeks.</td>
<td>Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reversed scores. The total score is calculated by adding together the scores for each of the ten items.</td>
<td>Source article indicates that with mothers, who scored above threshold, 92.3% were likely to be suffering from a depressive illness of varying severity.</td>
<td>Less than five minutes</td>
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</table>

https://www.tnaap.org/programs/behavioral/screening-guidelines
General Development (Including social language, motor, cognitive, self-help)
Birth till age nine

General developmental screens are indicated for older children (school age or above) only if it is suspected that a developmental problem has not been previously detected and/or diagnosed. Children beginning school and in early primary grades may benefit from developmental screen as a means to detect learning problems.

<table>
<thead>
<tr>
<th>Name of Screen</th>
<th>Age Range for Screen</th>
<th>Description</th>
<th>Scoring</th>
<th>Accuracy</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ages &amp; Stages (ASQ)</strong></td>
<td>0-60 months</td>
<td>Covers 19 different age intervals. Each questionnaire contains 30 developmental items written in simple, straightforward language, with reading levels ranging from fourth through sixth grade. Each of the 19 questionnaires (for a specific age interval) covers the following areas: communications gross and fine motor, problem solving and personal-social. Clear drawings and simple directions help parents indicate children’s skills. These are separate copyable forms of 10 to 15 items for each age range (tied to health supervision visit schedule). Can be used in mass mail-outs for child-find programs. Available in English, French, Spanish and Korean.</td>
<td>Single pass/fail score</td>
<td>Sensitivity ranges from 70% to 90% at all ages except the 4-month level. Specificity ranges from 76% to 91%.</td>
<td>Scoring takes about 7 minutes; questionnaire can be completed in 10-20 minutes.</td>
</tr>
<tr>
<td><strong>Brigance Screens</strong></td>
<td>21 to 90 months</td>
<td>Seven separate forms, one for each 12 month range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observations. Acceptable as a screen, but due to extensive direct testing, used more often as a secondary screen.</td>
<td>Cutoff and age equivalent scores</td>
<td></td>
<td>10 minutes (direct testing only)</td>
</tr>
<tr>
<td>Name of Screen</td>
<td>Age Range for Screen</td>
<td>Description</td>
<td>Scoring</td>
<td>Accuracy</td>
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<tr>
<td><strong>Child Development Inventories</strong></td>
<td>Birth to 72 months</td>
<td>60 yes/no descriptions with separate forms for 0-18 months. <em>Infant Development Inventory (IDI)</em> 18-36 months; <em>Early Child Development Inventory (ECDI)</em> and 3 years to Kindergarten. <em>Preschool Development Inventory (PDI)</em> includes a developmental milestones chart for the first 21 months of life span, across five domains (social, self-help, gross and fine motor and language.) Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.</td>
<td>A single cut-off tied to 1.5 Standard Deviations below the mean</td>
<td>Sensitivity was 75% or greater across studies and specificity was 70%</td>
<td>About 10 minutes (if interview needed)</td>
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<tr>
<td><strong>Child Development Review</strong></td>
<td>18 months to kindergarten</td>
<td>6 questions for parents and 26 item possible behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language. Development and age norms are based on research with the Child Development Inventories (see above) problems list, backed with a First Five Years Child Development Chart. The chart can be used for observation, as a parent interview guide, or as parent education tool. The CDR helps determine whether a child’s development is “normal”, “borderline”, or “delayed” in five development areas; energy, motor symptoms, language symptoms, behavioral and emotional problems. The chart that is included can be used as a parent interview guide or to observe and record development in five areas: social self-help, gross and fine motor, and language.</td>
<td>Parents’ responses to the six questions and problem checklist are classified as indicating 1) No Problem, 2) a Possible Problem, or 3) Possible Major Problem. The Child Development chart results are compared to age norms, and classified as “typical” for age in all areas or as “borderline” or “delayed” in one or more areas of development. Guidelines for identifying indicators of need for follow-up are described in the manual.</td>
<td>Sensitivity 68% or greater. Specificity 88%</td>
<td>5 minutes (if interview needed)</td>
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<thead>
<tr>
<th>Name of Screen</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Parents’ Evaluations of Developmental Status (PEDS)</td>
<td>Birth to 9 years</td>
<td>10 questions eliciting parents’ concerns. Can be administered in waiting rooms or by interview. Available in English and Spanish. Written at the 5th grade level. Normed in teaching hospitals and private practice.</td>
<td>Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring</td>
<td>Sensitivity ranged from 74% to 79% and Specificity ranged from 70% to 80%.</td>
<td>About 2 minutes (if interview needed)</td>
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### Autism & Pervasive Developmental Disorders (PDD) 12 months through 36 months of age

Depending upon screening tool used and age of child at time of screen, child should be screened once during 12 to 36-month age interval.

<table>
<thead>
<tr>
<th>Name of Screen</th>
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<th>Description</th>
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<th>Accuracy</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified Checklist for Autism in Toddlers (M-CHAT).</td>
<td>18 months of age</td>
<td>Consists of 23 yes/no questions using the original nine from the CHAT. Goals of the M-CHAT are to improve the sensitivity of the CHAT and position it better for an American audience.</td>
<td>Child fails the checklist when 2 or more critical items or any three items are failed. Since it is a screen, a “failing” score is viewed as a need for further evaluation as not all children who have a failing score meet the criteria for a diagnosis on the autism spectrum.</td>
<td>Authors indicate that research is pending on sensitivity and specificity</td>
<td>About five minutes</td>
</tr>
<tr>
<td>Name of Screen</td>
<td>Age Range for Screen</td>
<td>Description</td>
<td>Scoring</td>
<td>Accuracy</td>
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<tr>
<td>Eyberg Child Behavior Inventory (ECBI)</td>
<td>2 ½ to 11 year (best used to age 4)</td>
<td>A total of 36 short statements of common behavior problems. A score of more than 16 suggest referral for behavioral interventions. Fewer than 16 enable the measure to function as a problem list for planning in-office counseling and selecting handouts.&lt;br&gt;Note: PEDS can also be used to screen possible behavioral problems up to age 9</td>
<td>Single refer/non-refer score for externalizing problems (e.g., conduct, attention, aggression)</td>
<td>Sensitivity 80%; Specificity 86%</td>
<td>About 7 minutes</td>
</tr>
<tr>
<td>PEDS</td>
<td>Note: The PEDS can also be used to screen possible behavioral problems up to age 9</td>
<td>See description above under General Development</td>
<td><code>- </code></td>
<td><code>- </code></td>
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</tr>
<tr>
<td>Pediatric Symptom Checklist (PSC)</td>
<td>6 to 18; with modification of items (see article, can be adapted for ages 4 &amp; 5)</td>
<td>35 short statements of problem behaviors to which parents respond with “never”, “sometimes”, or “often”. The PSC screens for academic and emotional/behavioral difficulties.</td>
<td>Single refer/non-refer score for externalizing problems (e.g., conduct, attention, aggression)</td>
<td>Sensitivity ranged from 80% to 95%; Specificity in all but one study was 70% to 100%</td>
<td>About 7 minutes (if interview needed)</td>
</tr>
<tr>
<td>PSC-17</td>
<td>4-18</td>
<td>17 short statements of problem behaviors to which parents respond with “never”, “sometimes”, or “often”. The PSC-17 screens for academic and emotional/behavioral difficulties, and includes three subscales (Aggression, Attention and Depression).</td>
<td>Cut-off scores of 7 or above for aggression and attention subscales; 5 or above for depression; or 15 or above for the entire 17 item screen.</td>
<td>Good sensitivities (.77 -.87) and specificities (.68 -.80) at the optimal cutoff points were reported in the Gardner et. al study.</td>
<td>Less than 7 minutes</td>
</tr>
</tbody>
</table>
Name of Screen: Indicates the name of the screen

Age Range for Screen: Indicates within what age range the specified screen should be administered.

Description: Provides information on alternative ways (if available) to administer measures (e.g., waiting rooms).

Scoring: Shows general information regarding pass/fail criteria and cut off scores.

Accuracy: Shows percentage of patients with and without problems identified correctly.

Time Frame: Shows the cost of professional time needed to administer and score each measure. For parent report measures, administration time reflects not only scoring of the results, but also each test’s reading level and the percentage of TennCare patients with less than a high school education (who may or may not be able to complete measures due to literacy problems and will this need office staff to read the screen to them).

References:
AAP Periodicity Guidelines (American Academy of Pediatrics recommendations for Preventive Health Care) (RE9939)
Developmental Surveillance and Screening of Infants and Young Children (RE0062)

ELEVATED BLOOD LEAD LEVEL SCREENING

A finger stick or venous blood test for lead screening is a required health standard for children in TennCare at ages twelve (12) and twenty-four (24) months. Children ages thirty-six (36) to seventy-two (72) months who have not previously had a lead screening should be tested. The participating lab will notify the Provider of all test results and BlueCare Tennessee Care Management when screening results reveal an elevated blood lead level of five (5)ug/dL and above. Providers should communicate with BlueCare Tennessee Care Management to coordinate comprehensive care for these members.

Confirmation by venous blood sampling must confirm elevated blood lead levels. The time between the initial lead level screening and a venous confirmation must be based on the following criteria:
## Recommended Actions Based on Blood Lead Level


<table>
<thead>
<tr>
<th>BLOOD LEAD LEVEL (µg/dL)</th>
<th>ACTIONS</th>
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</table>
| >70                     | - Immediately conduct a complete medical evaluation.  
- Consider hospitalization to commence chelation therapy (following confirmatory venous blood lead test).  
- Consider consultation from a medical toxicologist or a pediatric environmental health specialty unit.  
- Proceed according to actions for 45-69 µg/dL. |
| 45 - 69                 | - Provide dietary and environmental lead poisoning education.  
- Follow-up blood lead monitoring*.  
- Conduct a complete history and physical examination.  
- Lab work: Hemoglobin or hematocrit, Iron status, Free Erythrocyte Protoporphyrin (FEP).  
- Refer for environmental investigation and lead hazard reduction.  
- Neurodevelopmental monitoring.  
- Abnormal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated.  
- Consider oral chelation therapy or hospitalization if lead-safe environment cannot be assured.  
- Test siblings 6-72 months of age. |
| 5 - 44                  | - Provide dietary and environmental lead poisoning education.  
- Follow-up blood lead monitoring*.  
- Conduct a complete history and physical examination.  
- Lab work: Hemoglobin or hematocrit, Iron status.  
- Refer for environmental investigation and lead hazard reduction.  
- Neurodevelopmental monitoring.  
- Abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated.  
- Test siblings 6-72 months of age. |
| <5                     | - Provide dietary and environmental lead poisoning education.  
- Environmental assessment** for pre-1978 housing.  
- Follow-up blood lead monitoring*.  
- No additional action necessary unless exposure sources change. |

*The higher the blood lead level, the more urgent the need for follow-up testing.
**The scope of an environmental assessment will vary based on local resources and site conditions. However, this would include at a minimum a visual assessment of paint and housing conditions. However, this would include at a minimum a visual assessment of paint and housing conditions. However, this would include at a minimum a visual assessment of paint and housing conditions. However, this would include at a minimum a visual assessment of paint and housing conditions. This may also include looking for exposure from imported cosmetics, folk remedies, pottery, food, toys, etc. which may be more important with low lead level exposure.
C. Interperiodic Screening

TennCare requires that under the TennCare Kids benefit, participating managed care organizations must provide vision, hearing, and dental screenings for children under the age of 21 years, at intervals which meet the reasonable standards of medical and dental practice.

In addition to the TennCare Kids screenings, "interperiodic" screenings must also be provided, when necessary. An interperiodic screening gives attention to a suspected problem to determine if additional diagnostic treatment services are needed; however, it does not have to include any screening elements required for a periodic screening.

The determination of whether an interperiodic screening is necessary may be made by a health, development, or educational professional who comes in contact with the child outside the formal health care system (e.g., Early Intervention Programs, Head Start, and nutritional programs such as the Special Supplemental Food Program for Women, Infants and Children). Likewise, parents, guardians, or family members can make determinations of whether an interperiodic screening is necessary when it is suspected that a child is having problems and needs further attention.

For example, a child who is screened at age 10 years according to the periodicity schedule for TennCare Kids screenings would not be due another screening until age 11 years. However, if six months later the child’s teacher suspects that the child is experiencing hearing problems, the school teacher should immediately refer the child to a Primary Care Provider for an interperiodic screening to determine if there is a problem needing further attention. There is no need to wait until the next regularly scheduled periodic screening.

TennCare Kids and interperiodic screenings do not require prior authorization; however, additional testing and treatment services must meet Medical Necessity criteria, when applicable. While the screenings are not subject to any cost-sharing responsibilities, these amounts may apply to any further diagnostic and treatment services if the Member has cost-sharing responsibilities.

D. Coordination of Care

All health care Providers are encouraged to share details of any services or preventive care provided to BlueCare Tennessee Members with the Primary Care Provider (PCP) shown on the Member’s ID card. Sharing this information will help assure the Member’s assigned PCP does not duplicate any services. Instead, only the age-appropriate services due will be provided at the Member’s next office visit.

Specialists, school clinics, health departments or other PCPs providing TennCare Kids services may document this information 1) on form, 2) on office notes, 3) in a memo, or 4) in a letter, and either fax or mail it to the assigned PCP’s office.

The assigned PCP’s office staff should include documentation of any TennCare Kids services received from other Providers in the Member’s medical record. If the TennCare Kids screening information is received PRIOR to the Member’s first PCP visit, a method should be established to assure this documentation is included in the Member’s chart at the time of the initial office visit.

The Division of TennCare has worked closely with the Department of Education and MCOs to help ensure coordination of care and the delivery of Medically Necessary services to school aged children. The Individualized Education Program (IEP) and the Individualized Family Service Plan (IFSP) for children with disabilities are legally mandated programs developed by a multidisciplinary team that specifies individual goals and services, including educational or Medically Necessary related services.
If you have any questions or need additional information regarding documentation requirements of TennCare Kids services, you may contact Provider Services at one of the numbers listed below:

BlueCare 1-800-468-9736
TennCare Select 1-800-276-1978

**School-based Services**

School-based Services is a process to provide information to BlueCare Tennessee when TennCare enrolled children are identified as needing to receive medically related services in an educational or out of school setting. The Division of TennCare has worked closely with the Department of Education and MCOs to ensure coordination of care and the delivery of Medically Necessary services to school aged children.

The Division of TennCare, which includes the CoverKids Program is committed to the coordination of school-based, Medically Necessary services and has worked closely with the Department of Education (DOE) and TennCare’s Managed Care Organizations (MCOs), including BlueCross BlueShield of Tennessee, dba BlueCare Tennessee (BCT), to ensure coordination of care and the delivery of Medically Necessary services to TennCare-enrolled school age children. For any Medically Necessary service provided in the school setting, TennCare continues to require that there is an Individual Education Plan (IEP) including that service and that a parental consent form has been obtained. BCT has decided not to require schools to send eligible students’ IEPs to BCT prior to BCT being responsible to pay for the covered, Medically Necessary services. Rather, BCT has decided to audit IEPs, as it does with other services, which means that each school must prepare and maintain updated IEPs for each eligible student and then provide any requested IEP to BCT upon request. At a minimum, BCT will be required to conduct regular post payment sample audits of IEPs and all other documentation to support the Medical Necessity of the school-based services reimbursed by BCT. When BCT requires a copy of an IEP, the Provider must also include a copy of the appropriate parental consent. TennCare has updated the authorization forms, which can be found at [https://www.tn.gov/tenncare/tenncare-kids/school-based-services.html](https://www.tn.gov/tenncare/tenncare-kids/school-based-services.html).

Additionally, the school can coordinate with BCT to arrange for services to be provided during school or outside of a school setting.

As a reminder, failure to abide by the requirements and requests of BlueCare may subject the school to recoupments and, potentially, other penalties. Finally, it is important to understand that BCT, in its discretion, may choose, in the future, to change this approach and begin requiring schools to submit all eligible students’ IEPs prior to the school being eligible to receive reimbursement for providing covered, Medically Necessary services.

Please note, the following BlueCare Tennessee guidelines still apply:

- Services billed should still meet the standards of being in an IEP;
- Services must be performed by a participating Provider;
- BlueCare Tennessee will conduct post payment audits on a sample of IEPs for Members who receive school-based therapy; and
- If requested, the school must send a copy of the IEP and the parental consent in support of the services.

Members under the age of 21 are identified as needing to receive physical, speech, occupational or behavioral health services in an educational or out-of-school setting through the Individualized Education Plans (IEP) process. BlueCare Tennessee covers Medically Necessary Covered Services in the school or out of school when the service is documented in the current IEP, performed by the appropriate Practitioner and parental consent has been obtained.
E. TennCare Kids Resources and Helpful Tips

All age and risk components required by TennCare Kids should be performed during the preventive visit. Coding services using preventive CPT® codes will help ensure Providers receive the highest level of reimbursement possible.

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) offers free coding training resources and reference materials that can help your practice file claims appropriately for preventive health screenings, maximize reimbursement, reduce administrative costs and improve audit outcomes. These programs are available onsite for your office staff and on the TNAAP website, [www.tnaap.org](http://www.tnaap.org). These include:

- AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)
- TNAAP Coding Guide – This is a comprehensive resource for coding assistance
- Chart Documentation Forms
- Early and Periodic Screening, Diagnosis and Treatment Manual
- Billing/Coding & Reimbursement Webinars
- Lead Screening

Additionally, BlueCare Tennessee offers quarterly TennCare Kids Provider Trainings*, some of which are in partnership with TNAAP. These training opportunities include:

- Most current Bright Futures/AAP recommendations for Preventive Services
- Seven components and documentation requirements for TennCare Kids visits and review the age-specific services recommended for each well child visit
- Proper coding, billing and reimbursement

*Refer to future BlueAlert newsletters and e-mails detailing the availability of TennCare Kids Provider Trainings opportunities or contact your Provider Network Manager.

The following are a number of Best Practices some Providers have initiated to help achieve maximum reimbursement for TennCare Kids services:

- **Pre-scheduling first year’s newborn checkups** - Scheduling a years’ worth of checkups for a newborn can give parents a plan to follow for their child. For babies, it helps keep a path of care in place even if they miss a well-care visit.

- **Converting sports physicals to complete well care visits to optimize Covered Services** – As a reminder, stand-alone sports physicals and their corresponding codes are not Covered Services. However, by converting that appointment into a complete well-care visit, Providers can meet all requirements of the sports physical and receive reimbursement for a Covered Service.

- **Combining well care visit with other types of visits, e.g., office visit for an illness, shots, prescription refills (TennCare Kids screening guidelines allow reimbursement for both “sick” and “well” visit on the same day)** – See below example of combining visit:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BlueCare</td>
</tr>
<tr>
<td>99212 Acute Visit</td>
<td>$29.55</td>
</tr>
<tr>
<td>99382 EPSDT Code</td>
<td>$91.61</td>
</tr>
<tr>
<td>Combined Codes</td>
<td>$121.16</td>
</tr>
</tbody>
</table>

Rev 03/18
Alternating and/or extending office hours to help ensure more kids have access to preventive care – Many times parents and others caring for children covered by BlueCare Tennessee have jobs that don’t allow them to bring their kids in for visits during normal office hours. Some practices have found offering appointment times later in the evening or on weekends helps ensure more kids get preventive care.

Transportation for your Patients - If you have patients who can’t get to their appointments for TennCare Kids services with you because they don’t have a ride, tell them they have an option. Southeastrans will get them to and from their visit with you at no charge.

Members can call one of the following numbers to schedule a ride:

- BlueCare East Region 1-866-473-7563
- BlueCare Middle Region 1-866-570-9445
- BlueCare West Region 1-866-473-7564
- TennCareSelect 1-866-473-7565

Electronic Medical/Health Records - Most of the EMR systems available have tools to help manage and schedule patient visits. Some practices are using automatic reminders to help see more patients and reduce missed visits. Others are tracking when patients are overdue for checkups or health screenings and contacting them with phone calls or letters.

Staff Dedicated to Checkups - Assigning staff specifically to check patient records and make scheduling calls or texts. Nurses, nurse practitioners and physician assistants who are available to triage sick children that could then be combined into a well-care checkup.

Note: Availity, the secure Provider portal on BlueCare Tennessee website, https://bluecare.bcbst.com/ has a feature within Quality Care Rewards that allows Providers to see a detailed list of their BlueCare Tennessee patients who are due a well-care visit, making patient outreach easier.

F. TennCare Kids Provider Training

BlueCare Tennessee offers quarterly TennCare Kids Provider Trainings.

These training opportunities include several elements to include:

- Information on the most current Bright Futures/AAP recommendations for Preventive Services;
- The seven components and documentation requirements for TennCare Kids visits; and
- Review for age-specific services recommended for each well child visit and how these services should be reported, coded, and billed.

We offer these services at various conferences, webinars and other venues. We will also provide information on how to convert sports physicals and sick visits to well child visits.

These training opportunities are specifically for Providers; however, billing, finance, coding, IT and other health center staff may attend.

Refer to BlueAlert newsletters and e-mails for details of future TennCare Kids Provider Trainings.
XXI. BEST PRACTICE NETWORK (BPN) PROVIDER MANUAL (A TennCare Select Sub-Network) (Does Not Apply to CoverKids)

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VI. General Information

Rev 12/15
I. Introduction

The Best Practice Network (BPN) is a sub-network of TennCareSelect, the State of Tennessee’s self-insured TennCare Health Maintenance Organization.

One of the groups identified by the State, as “select populations” is children in state custody or at risk for entering state custody. In order to support these children, this special sub-network was created within TennCareSelect. This sub-network includes Primary Care Providers (PCPs) who have agreed to serve the health care needs of this unique population and to fulfill special roles and responsibilities associated with the management of children in state custody. The Best Practice Network Primary Care Provider (BPN PCP) administers basic health care and coordinates all physical and behavioral health care for the children assigned to him/her.

The BPN PCP is responsible for providing a “medical home” for these children and maintaining all health records for the child, regardless of where the care is provided. All Providers are required to forward medical records to the BPN PCP so that a comprehensive medical record can be maintained.

TennCare Enrollees who are children in the custody of the Department of Children’s Services (DCS) will be enrolled in TennCareSelect. Throughout this Manual, SelectKids will be used to denote this Member population.
II. How to Identify SelectKids Members

A. Immediate Eligibility for Children in State Custody

TennCareSelect accepts notification from DCS that a child has entered State custody as proof of eligibility until a final determination can be made on their TennCare eligibility to insure there is not a delay in services. TennCareSelect offers immediate eligibility for children not enrolled in the TennCare program for a period of forty-five (45) days from the custody date. Children with current eligibility will remain with their previous MCO until official notification is received on an eligibility file from TennCare. This provides children in State custody adequate access to services, including TennCare Kids, until a final determination can be made on their TennCare eligibility. When these Enrollees exit State custody, they remain enrolled in TennCareSelect for a specified period of time and then are disenrolled from TennCareSelect.

B. Initial Enrollment of SelectKids Member

Until a final determination can be made on a child’s TennCare eligibility, TennCareSelect accepts notification from DCS that a child has entered State custody. A faxed notification is submitted to indicate the need for eligibility and the child is provided forty-five (45) days of “Immediate Eligibility”. A fax is then sent to the DCS informing them of the child’s eligibility status. This fax serves as proof of eligibility for all TennCare-covered benefits and BPN Providers should accept the fax in lieu of the TennCareSelect plastic ID card.

When the Division of TennCare approves the child for permanent eligibility, BlueCare Tennessee will issue a permanent TennCareSelect plastic ID card assigning the Member to a BPN PCP. Once the child is released from State custody, the State will determine whether the child will be returned to the previously assigned MCO (if applicable) or remain with BlueCare Tennessee.

The SelectKids Member will receive a plastic TennCareSelect ID card reflecting the TennCareSelect logo. Primary Care Provider’s (PCP’s) name, effective date, and any applicable copayment amount. In order to identify the SelectKids Member, the ID card will reflect “SelectKids” in the lower left-hand corner. A new ID card is issued each time the Member changes PCPs and will reflect the new PCP name.

A sample copy of the TennCareSelect SelectKids Member ID Card follows:

![Sample ID Card Image]
Customer Service inquiries for SelectKids Members should be directed to:

<table>
<thead>
<tr>
<th>Provider Services</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Provider and Family Services Worker)</td>
<td>1-800-451-9147</td>
<td>1-800-330-2842</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Management</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Notification/Prior Authorization)</td>
<td>1-800-711-4104</td>
<td>1-800-292-5311</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Services</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-888-422-2963</td>
<td>1-800-330-2482</td>
</tr>
</tbody>
</table>

C. PCP Membership Listing

The PCP Membership Listing is a report providing PCPs with eligibility information for those Members assigned to his/her membership based on the PCP’s network participation status, e.g. BlueCare, TennCareSelect, and/or Best Practice Network. The listing is comprised of enrollment information received from the Division of TennCare. Any Member eligibility changes received from the state subsequent to the issuance of the report are reflected on the PCP Membership Listing. PCP Membership listings are available electronically via Availity, BCBST’s secure area on its company websites, [http://bluecare.bcbst.com](http://bluecare.bcbst.com) and [www.bcbst.com](http://www.bcbst.com).

D. SelectKids Member Transition (out of state custody)

SelectKids Members transitioning out of state custody shall have access to a BPN PCP for a specified period of time. During the transitioning period, the Member will remain in the TennCare Select Kids Program and will continue to have his/her care coordinated by a BPN PCP or a TennCare Select PCP. (Unless the Division of TennCare terminates the Member’s eligibility before the transitional period ends.)

When a SelectKids Member moves out of state custody and completes the transitional period, the state will change the Member’s eligibility; e.g., remain with TennCare Select or return to previously assigned MCO. Although the Member will be reclassified from a SelectKids Member to a TennCare Select Member, he/she will remain with his/her current PCP, if appropriate. A new Member ID card will be issued that does not reflect the “SelectKids” identifier and the PCP is no longer responsible for the additional roles and responsibilities required when caring for a SelectKids Member. In addition, the enhanced care management fee would no longer apply.
III. BPN Provider Roles and Responsibilities

The Best Practice Network is composed of Primary Care Providers (PCPs) who have agreed to provide appropriate care for SelectKids Members who are more difficult to serve because of their health care needs, their mobility, and/or their geographic location.

A. BPN Primary Care Provider (BPN PCP)

BPN PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of SelectKids Members. In return for the additional efforts in caring for SelectKids Members, BPN PCPs receive a higher reimbursement rate for initial TennCare Kids services and a monthly care management fee.

1. Primary Care Management

- Provide TennCare Kids screenings timely if requested by DCS Family Services worker;
- Provide not only the basic health care, but also care coordination of all the health care services of children in custody;
- Refer to physical and behavioral health professionals in the Best Practice Network for specialty care; refer to the Center of Excellence (COE) for children in, or at risk, of state custody, Community Mental Health Center (CMHC) when indicated; coordinate referrals as applicable;
- Request telephone consultations with Center of Excellence when indicated;
- Communicate with caregivers on plan of care;
- Maintain all health information on children assigned to them regardless of who provides the care (Center of Excellence for children in, or at risk, of state custody, local specialist, behavioral health provider, other health care providers);
- Report to the Department of Children’s Services (DCS) Health Unit anytime health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care;
- Forward medical files to a newly assigned PCP and provide an initial consult when a child is being transferred to a new geographical area or new MCO;
- Share health information with the DCS and resource parents within confidentiality guidelines;
- Forward pertinent information to providers seeing child on referral;
- Utilize (and document usage) Best Practice Guidelines for care when developed and adopted by the Steering Panel. Document rationale for variation from Best Practice Guidelines;
- Review information provided by state or MCO on caring for children in state custody;
- Participate in the evaluation of system and outcomes through representation on the CSHN Steering Panel;
- Participate in the MCO selected for children in custody;
- Participate in training* related to health problems of children in custody or Best Practice Guidelines; and
- Develop health treatment plans and incorporate all the treatment needs of the children they see.

* BlueCare Tennessee is responsible for developing a survey to be administered after each COE training session to solicit feedback on barriers to attendance from non-attending BPN PCPs. Results of this survey and recommendations for increasing participation must be provided to the Division of TennCare within ninety (90) days of the COE training session.

Note: Time frames for information gathered and follow-up are governed by the policies and procedures of the Best Practice Network as directed by the Division of TennCare.
2. Case Management

The PCP is the case manager in the health network because this is the Practitioner that all children have. The role of the PCP as case manager is:

- Maintenance of all health information on the children including behavioral health;
- Coordinate health services and request assistance from the DCS Family Services worker in following up and assuring plan of care is implemented;
- Consult with Center of Excellence or other behavioral health providers when additional help is needed in managing a case; and
- Notify the DCS when he/she feels more intense case management is needed by the DCS.

Note: Time frames for information gathered and follow-up are governed by the policies and procedures of the Best Practice Network as directed by the Division of TennCare.

3. Behavioral Health Services Rendered by a BPN PCP

At present, BPN PCPs may continue to render Behavioral Health services within the scope of his/her practice and bill BlueCare Tennessee as outlined in Section VIII. Utilization Management of this Manual.

4. Referrals for Specialty Care

BPN PCPs should utilize the TennCare Select Network for specialty, facility, and ancillary medical care.

5. Coordination of Care

Coordination of care is an integral process that ensures continuity of care for SelectKids Members. When services are rendered to a SelectKids Member, the Provider rendering the service should communicate the information related to the encounter to the BPN PCP either through the BPN Medical Record Update form or via letter, which contains all the information requested on the form.

6. BPN PCP Care Management Fee

BPN PCPs receive a $10.25 per Member per month Best Practice Network Care Management Fee as compensation for their agreement to fulfill the Best Practice Network PCP Roles and Responsibilities. No minimum enrollment is required.

7. TennCare Kids Screening

Every child under the age of 21 years is eligible for TennCare Kids services and should receive checkups, even if there is no apparent health problem. The BPN PCP is expected to provide a “medical home” for the SelectKids Members assigned to him/her. SelectKids Members may pose special management issues because they may have incomplete or poorly documented health records and they may present to the BPN PCP without a reliable medical history.

Effective June 15, 2003, the Department of Children’s Services (DCS) began scheduling all TennCare Kids services for children entering state custody with health departments. The Division of TennCare and the DCS made this decision in a continuing effort to comply with federal TennCare Kids guidelines. (See Health Department Services section for more information on this process.)
The BPN PCP may provide preventive/TennCare Kids services. The following offers guidelines when TennCare Kids services are appropriate:

- If the child had a screening on schedule and prior to entering state custody, and DCS can provide the BPN PCP access to those records, and there is no indication that an inter-periodic screen is indicated (untreated or worsening medical or behavior problem), then there is no need to repeat the screen.

- A repeat screen is necessary if the results of the last screen are:
  - not available; or
  - the last screen identified problems that were not followed-up; or
  - identified problems have worsened or persisted; or
  - there is reason to suspect abuse; or
  - no problems were identified, but medical or behavioral problems contributed to the child entering into the Best Practice Network.

- If the SelectKids Member presents to the BPN PCP with an inadequate history and unreliable historian, the BPN PCP should complete as much screen as possible, notify the DCS Family Services worker of what additional information is needed, and reschedule the Member for a follow-up interperiodic exam (See Section XX. TennCare Kids in this Manual for details on Interperiodic Screening).

TennCare Kids periodic screening examination has the following seven required components:

1. Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
2. Comprehensive unclothed physical examination including measurements (the child’s growth shall be compared against that considered normal for the child’s age and gender);
3. Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;
4. Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as Medically Necessary to determine the existence of suspected illness or condition;
5. Appropriate laboratory tests (including lead toxicity screening for age and risk factors). All children are considered at risk and shall be screened for lead poisoning; and
6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and
7. Health education which includes anticipatory guidance.

Pursuant to the TennCare/MCO Contractor Risk Agreement Section 2.7.6.3.2, “At a minimum, these screens shall include periodic and interperiodic screens and be provided at intervals which meet reasonable standards of medical, behavioral, and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care. The State has determined the ‘reasonable standards of medical and dental practice’ are those standards set forth in the American Academy of Pediatrics Recommendations For Preventive Pediatric Health Care for medical practice and American Academy of Pediatric Dentistry (AAPD) guidelines for dental practice. Tools used for screening shall be consistent with the screening guidelines recommended by the State which are available on the TennCare website. These include, but are not limited to recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings, and vision screenings.”
8. Periodicity Schedule and Preventive Visit Forms
The periodicity schedule defines the intervals for screening and is based on American Academy of Pediatric recommendations (1999), and Division of TennCare guidelines. The Periodicity Schedule should be used in determining the correct ages to perform preventive visits as well as to determine the age-appropriate screening. More frequent screening should be done as medically indicated. All of the age-appropriate screening components must be completed in each preventive checkup visit.

Guidelines, periodicity schedules, standard preventive visit encounter forms, and standard development screening tools can be found in the TennCare Kids Tool Kit located on the company website, https://bluecare.bcbst.com/providers/tools-resources/general/programs-services-faqs.html.

9. TennCare Kids Billing Guidelines
Coding TennCare Kids services using appropriate preventive CPT® codes will help ensure Providers receive the highest level of benefits possible. Note: BlueCare Tennessee shall recoup an amount equivalent to the difference between the enhanced Best Practice Network TennCare Kids screening reimbursement and the standard TennCareSelect TennCare Kids screening reimbursement if it is determined, upon medical chart review that the Provider to whom payment was made, failed to complete all seven (7) components of the exam.

Preventive codes:

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 under 1 year</td>
<td>99391 under 1 year</td>
</tr>
<tr>
<td>99382 1-4 years</td>
<td>99392 1-4 years</td>
</tr>
<tr>
<td>99383 5-11 years</td>
<td>99393 5-11 years</td>
</tr>
<tr>
<td>99384 12-17 years</td>
<td>99394 12-17 years</td>
</tr>
<tr>
<td>99385 18-39 years</td>
<td>99395 18-39 years</td>
</tr>
</tbody>
</table>

Developmental Screening Code

96127

In addition to the preventive visit codes, the Division of TennCare has approved CPT® code 96127 for administration of standardized, validated developmental screening questionnaires, e.g., Parents’ Evaluation of Developmental Status/PEDS; Pediatric Symptom Checklist/PSC; Child Development Inventories.

CPT® 96127 will be reimbursed separately from any preventive visit code listed above.

Note: Prior to 1/1/15, procedure code 96110 was billed for the Pediatric Symptoms Checklist. Procedure code 96110 is still a valid code for current dates of service and can be billed for the appropriate services.

Newborn Care (History and Examination)

99460

Normal Newborn Care

99461

TennCare Kids Services Billed with Evaluation & Management codes
Effective Oct. 1, 2015, claims for preventive services must be filed using the appropriate CPT® code with the appropriate diagnosis code. Use of these codes is required in order for the encounter to be considered a complete TennCare Kids screening reimbursable at the enhanced rate. Previously, providers were required to use a “V” diagnosis code in conjunction with preventive procedure codes to receive the enhanced rate.
**BlueCare Tennessee**  
**Provider Administration Manual**

*Modifier 25 may be billed on an Evaluation and Management (E&M) service when performed at the same session as a preventive care visit when a significant separately identifiable E&M service is performed in addition to the preventive care.* The E&M service must be carried out for a non-preventive clinical reason and ICD code(s) for the E&M service should clearly indicate the non-preventive nature of the E&M service.

**Evaluation & Management codes**

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
</tr>
<tr>
<td>99204</td>
<td>99214</td>
</tr>
<tr>
<td>99205</td>
<td>99215</td>
</tr>
</tbody>
</table>

Members under age 21 years who are receiving prenatal care are also eligible to receive TennCare Kids services from their obstetrician. Providers may bill a preventive code, plus an Evaluation & Management code with modifier 25 when the visit includes both preventive care and prenatal services.

**B. Dental Provider**

The Division of TennCare and DentaQuest entered into an arrangement where DentaQuest administers and manages dental services for all TennCare Members for all Managed Care Organizations. Administration changes include, but are not limited to:

- DentaQuest distributes its own Dental Provider Directory.
- DentaQuest handles all customer service.
- DentaQuest processes all claims.

If you have any questions or need additional information, please call DentaQuest Customer Service at 1-877-418-6886.

Anytime a SelectKids Member is seen by a Dentist, a copy of the medical record encounter must be sent to the SelectKids Member’s PCP. Providers may call DentaQuest toll-free at 1-800-294-9650 for help in locating a DentaQuest participating dentist.

(See Section XXI, V. B-C. for medical record instructions and sample copies of the medical record update and release of information forms.)

**C. Behavioral Health Provider**

Referrals to Behavioral Health Providers should be made whenever the SelectKids Member’s screening tests (TennCare Kids or Interperiodic) indicate a problem that the BPN PCP does not feel comfortable treating, or whenever the BPN PCP, DCS Family Services worker, or resource parent feels it is necessary.

Behavioral health services for SelectKids Members are coordinated through BlueCare Tennessee, along with Practitioners contracted with the Department of Children’s Services, Centers of Excellence, and the Health Service Team, each having specific roles and responsibilities. (See Important Contact Information grid, Section I, this Manual for PCPs having behavioral health questions.)

Rev 09/17
Anytime a SelectKids Member is seen by a Behavioral Health Provider, a copy of the medical record encounter must be sent to the SelectKids Member’s PCP. (See Section XXI, V. B-C. for medical record instructions and sample copies of the medical record update and release of information forms.)

D. Health Department Services

The Department of Children’s Services (DCS) Family Services worker schedules all TennCare Kids services with local health departments for children in state custody.

When the health department performs any portion of a TennCare Kids screening, a one-page form letter will be completed and forwarded to the DCS Family Services worker and the child’s assigned Primary Care Provider (PCP). This letter documents which screens were completed and notes any needed follow-up care that may be required. If a need for additional services is determined, the child will be referred to his/her assigned PCP for those services. This policy (see the State of Tennessee Department of Children’s Services Administrative Policies and Procedures, 20A.7 on the State of Tennessee’s website at www.tn.gov in no way precludes the PCP from providing any medical services he/she deems appropriate when treating these children.

(See Section XXI. V. B-C. for medical record instructions.)

E. Clinical Health Records

In an effort to enhance coordination of care for children in state custody who are enrolled in the TennCare Select program (SelectKids), BlueCare Tennessee provides Clinical Health records on request to Best Practice Network (BPN) Providers.

The promotion of early awareness of the Member’s past and current medical information helps the PCP address specific needs and more effectively coordinate care.

The Clinical Health Record allows Providers to view the Member’s past and current medical information including:

- Basic patient demographics
- Medical claims encounter data
- Medication history
- Gaps in care
- Immunization records
- Lab results
- Allergy information
- Primary care Provider contact information
- TennCare Kids services (Early Periodic Screening, Diagnosis, and Treatment)

This information is available to any clinician, specialist, or hospital participating in the Best Practice Network.

To request a detailed Clinical Health record for a SelectKids Member, e-mail the Member’s name, ID number, and date of birth to SelectKids_GM@bcbst.com.

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IV. Department of Children’s Services (DCS)

A. Roles and Responsibilities

The Department of Children’s Services is responsible for seeing that children in state custody receive appropriate health services, including arranging appointments for TennCare Kids services.

Through care coordination and case management services, the DCS assures that health care services are provided with reasonable promptness and directs caregivers to the Health Services Team in arranging behavioral health services. The DCS also assists specialty and behavioral health providers in forwarding medical records to each child’s assigned PCP when he/she receives services.

B. DCS Well Being Staff

BPN PCPs are responsible for reporting to the DCS Well Being Unit anytime health information on a child is not forwarded in a timely manner to allow for appropriate evaluation and care. If you are not receiving medical records for medical and behavioral health services, Providers can contact the Regional Administrator in his/her county. For the most current DCS Well Being Staff List please contact the SelectKids Unit at 1-800-451-9147.
Best Practice Network Providers face several issues concerning confidentiality, sharing of records and informed consent when treating SelectKids Members. These issues are inter-related due to the involvement of various agencies and the multidisciplinary care that these children require.

The following guidelines are compilations of the DCS and TennCare rules and regulations; American Academy of Pediatrics (AAP), Tennessee Medical Association (TMA), and American Medical Association (AMA) opinions; the Tennessee Code Annotated Title 33 and Federal Regulations Title 42 regarding confidentiality of records and consent. They are intended to aid PCPs in addressing concerns, but it is understood that the complex nature of this population of children make it impossible to address all scenarios.

A. Confidentiality and Informed Consent

1. A Practitioner may perform emergency medical or surgical treatment on a minor despite the absence of parental consent or court order if the Practitioner has good faith belief that delay in care would result in worsening of the medical condition and the provision of such care would further deteriorate the condition.

2. By case law in Tennessee, the common law Rule of Sevens applies to minors. A child age 14 through 17 is presumed to be competent to seek their own medical care without the knowledge and consent of their parents or legal custodians. The child must be counseled to determine that the child actually is competent, and the record must reflect such determination by the caregiver. Release of medical records of such an individual age 14 through 17 must be signed by the child and cannot be given to the parent or custodian without such release. If it is determined that the child is incompetent, the services should not be provided without consent of the legal guardian or parent.

A child 7 through 13 is presumed to be incompetent to seek their own medical care. However, if counseling of the child shows the child is competent, the medical services may be provided. The child's medical record must reflect such counseling and determination.

A child under the age of 7 is incompetent to seek his/her own medical care, and no care can be provided without the consent of the parent or custodian. The Practitioner should encourage the minor to involve the DCS Family Services worker, resource parent, or guardian, but should respect the wishes of the minor in aspects of confidentiality.

Specific examples include:

a. Practitioners may treat juvenile drug abuses without prior guardian consent. Practitioners should use their own discretion in determining whether to notify the child’s guardian.

b. A Practitioner may diagnose, examine, and treat a minor without knowledge or consent of the legal guardian for purposes of providing prenatal care.

c. Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian.

b. The Practitioner may diagnose and treat STDs without the knowledge or consent of the parent or guardian. Legal reporting requirements to the Department of Health still exist.

e. Confidentiality may be breached in situations where necessary to avert harm; e.g., threat of suicide or bodily harm to other individuals or situation in which the child’s behavior places him/her at significant risk.

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B. Medical Records

1. The following individuals may request and receive copies of the child’s medical records:
   a. The custodian of a minor. Either parent (whether custodial or not) can request a copy of the child’s records, unless parental rights have been terminated by a court, the child’s consent as per Rule of Sevens applies.
   b. For mental health records, a juvenile 16 years of age or older.
   c. A court having jurisdiction over the child.
   d. In cases where parent or guardian has been accused of abuse of the child, the records may be withheld from that individual. In addition, record release may be withheld, if a Physician feels that making a record available to an individual would jeopardize a child’s will being. When release of medical information is not in the best interest of the child, the PCP should immediately contact the DCS Family Services worker that can contact the juvenile judge to direct limitations to the release of records.

2. The federal law addressing school records is the Family Rights and Privacy Act (FERPA). Exceptions to requiring parental consent for disclosure include a school official with legitimate educational interests, and this is further defined as including a medical consultant. However, it is recommended that the PCP work with the DCS Family Services worker to assure that all non-medical providers, such as the school system, receive a release of information form and assure that the PCP also has a reciprocal form to share information with the school or other community agencies involved in the child’s care.

3. A DCS Family Services worker, biological parent (unless rights have been terminated by a court), or the resource parent can accompany the child to the office and can consent to treatment. The DCS should provide twenty-four hours, seven-days-a-week availability to the PCP of an authorized representative able to sign on behalf of the child to cover situations when the above mentioned are not available.

4. When a child sees another Practitioner on a referral, a Release of Information form should accompany the child. The Release of Information form can be found on BlueCare Tennessee’s website at https://bluecare.bcbst.com/providers/forms.html.

5. Any information received by the PCP from other health care Providers shall become part of the PCP’s chart and may be shared along with any other information in the child’s record. Likewise, any information the PCP provides to another Practitioner shall become part of the record of that Practitioner.

C. Health Services Confirmation and Follow-up Notification Form and Release of Information Form

The Department of Children’s Services utilizes the Health Services Confirmation and Follow-up Notification Form when children receive health services. It is requested that this form be completed and sent to the appropriate Well Being Unit when services are rendered as well as the BPN PCP for inclusion in the Member’s medical record.

When a child sees another Provider on a referral, a Release of Information form should accompany the child. Any information received by the PCP from other health care Providers shall become part of the PCP’s chart and may be shared along with any other information in the child’s record. Likewise, any information the PCP provides to another Practitioner shall become part of the record of that Practitioner.

If you have difficulty obtaining a SelectKids Member’s medical records, please call the SelectKids unit at 1-800-451-9147.

The Health Services Confirmation and Follow-up Notification Form can be found on the state’s website at https://www.tn.gov/dcs/for-providers/contract-provider-manual/provider-forms-and-documents.html.

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**VI. General Information**

SelectKids Member benefits are the same as all other TennCare covered benefits. Additionally, all medical management and billing guidelines apply. The grid below directs you to the appropriate sections in this Manual for general information and specific policies and procedures as they relate to the TennCare Select Program:

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XXII. CHOICES (Long-Term Services and Supports (LTSS))
(Does Not Apply to CoverKids)

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I. Introduction

The TennCare CHOICES Long-Term Services and Supports (LTSS) (CHOICES) program is a Medicaid system redesign initiative that integrates long-term services and supports, including nursing facility services and Home and Community-Based Service (HCBS) alternatives to nursing facility care, into the existing TennCare managed care delivery system. The primary goals of CHOICES are to:

- Provide streamlined, timely access to LTSS;
- Expand access to and utilization of cost-effective HCBS alternatives to nursing facility care;
- Serve more people with existing LTSS funds;
- Increase HCBS options;
- Improve coordination of all Medicaid (acute, behavioral and LTSS) services; and
- Rebalance LTSS spending (i.e., funding spent on institutional versus HCBS).

CHOICES promotes quality and cost-effective coordination of care for eligible CHOICES Members with chronic, complex, and complicated health care, social service and custodial needs in a Nursing Facility or Home and Community-Based Care setting. Care Coordination involves the systemic process of assessment, planning, coordinating, implementing and the evaluation of care received through a fully integrated physical health, behavioral health, and LTSS program to ensure the care needs of the Member are met.
II. Eligibility/Enrollment

To be eligible for enrollment in the CHOICES program, an individual must:

- for Groups 1 and 2, need the level of care provided in a nursing home;
- for Group 3, in the absence of HCBS, are “at-risk” for nursing facility care; and
- qualify for Medicaid long-term services and supports.

If currently enrolled in BlueCare or TennCare Select – call the customer service number on the back of the Member ID card.

During the enrollment process, the BlueCare Tennessee Intake staff is responsible for evaluation of the reasonable expectation that an individual's needs can be adequately met in the individual's choice of residence by the CHOICES program. If the determination is made that the individual cannot be served by CHOICES, the Enrollee shall be informed of the right to appeal in compliance with TennCare Rule 1200-13-13.

**CHOICES is made up of three (3) Groups, each with distinct eligibility/enrollment requirements and benefits:**

**Group 1**
Medicaid enrollees of all ages who are receiving Medicaid-reimbursed long-term services and supports in a nursing facility.

**Group 2**
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as Members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

**Group 3**
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

**TennCare determines if the Member meets eligibility criteria for Groups 1, 2, or 3.**

- For Groups 1 and 2, TennCare determines that the Member meets nursing facility level of care, including for Group 2, that the Member needs ongoing CHOICES HCBS in order to live safely in the home or community setting and to delay or prevent nursing facility placement.
- For Group 2, BlueCare Tennessee or, for new TennCare applicants, TennCare or its designee determines that the Member's combined CHOICES HCBS; private duty nursing and home health care can be safely provided at a cost less than the cost of nursing facility care.
- For Group 3, TennCare determines that the Member meets the at-risk level of care.
- For Groups 2 and 3, if there is an enrollment target, (the number of persons the State will allow in the Group) TennCare determines that the enrollment target has not been met or, for Group 2, approves the BlueCare Tennessee request to provide CHOICES HCBS as a cost-effective alternative.
- Members transitioning from a nursing facility to the community will not be subject to the enrollment target for Group 2, but must meet categorical and financial eligibility for Group 2.
Enrollment Process
The following outlines the CHOICES enrollment process:

1. BlueCare Tennessee screens BlueCare Medicaid referrals from all sources, including those referred by TennCare and the Area Agencies on Aging and Disability (AAAD) for potential eligibility for the CHOICES program. The AAADs are the Single Point of Entry (SPOE) for non-Medicaid applicants seeking access to CHOICES services. Referrals from non-Medicaid recipients are forwarded to the AAAD and referrals for another MCO Member are referred to the applicable MCO. The screening consists of a financial assessment and eligibility for nursing facility level of care. An important part of the screening process is to advise the individual or family member acting on behalf of the individual, of the CHOICES program qualifications and benefits including nursing facility and CHOICES HCBS options.

2. BlueCare Tennessee will visit potentially eligible BlueCare individuals and prepare an assessment of the individual’s needs. Intake staff will review the individual’s right to Freedom of Choice between nursing facility care and the CHOICES HCBS.

3. The Intake staff will review the Member Handbook and the Member’s needs; answer questions related to the CHOICES program and the individual’s care, and in collaboration with the Member, the Care Coordinator will complete any required forms.

4. The Members are provided an up-to-date electronic list of Service Providers for their area. Members are required to select their preference of Service Providers along with alternatives in the event their first choice is not able to provide the service.

5. Enrollment into CHOICES is not final until the Member information is transmitted from the Division of TennCare to BlueCare Tennessee via the electronic 834 enrollment file. Notification via the 834 occurs after TennCare approves financial eligibility and Nursing Facility level of care for Groups 1 and 2, or “at-risk” criteria for enrollment into Group 3.

Upon enrollment, each CHOICES Member receives a plastic Member ID card reflecting his/her Primary Care Provider (PCP) name and effective date. A new ID card is issued each time the Member changes his or her PCP. The single contact number for BlueCare Tennessee CHOICES is located on the back of the ID card.

Sample copy of BlueCare CHOICES Member ID card

Sample copy of TennCare Select CHOICES Member ID card

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CHOICES Members receive the same benefits as all other BlueCare and TennCare Select Members (see Section IV. Benefits, in this Manual). Additionally, the following long-term services and supports are available to CHOICES Members when the services have been identified as needed by the BlueCare Tennessee Care Coordinators and are included in the signed Person Center Plan of Care (PCSP).

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<tr>
<td>Nursing facility care</td>
<td>X</td>
<td>Short-term only (up to 90 days)</td>
<td>Short-term only (up to 90 days)</td>
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<tr>
<td>Community-based residential alternatives include:</td>
<td></td>
<td></td>
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<tr>
<td>1. Assisted Care Living Facility</td>
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<td>X</td>
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<tr>
<td>2. Critical Adult Care Homes</td>
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<td></td>
<td>X</td>
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<tr>
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<td></td>
<td></td>
<td>X</td>
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<tr>
<td>4. Community Living Supports Family Model</td>
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<td></td>
<td>X</td>
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<tr>
<td>5. Companion Care</td>
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<tr>
<td>Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Attendant care visits lasting for a period of more than four (4) hours or visits less than four (4) hours apart (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>Home-delivered meals (up to 1 meal per day)</td>
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<td>X</td>
<td>X</td>
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<td>Personal Emergency Response Systems (PERS)</td>
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<td>X</td>
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<tr>
<td>Adult day care (up to 2080 hours per calendar year)</td>
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<td>X</td>
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<td>In-home respite care (up to 216 hours per calendar year)</td>
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<td>X</td>
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<td></td>
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<td>X</td>
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<td>Assistive technology (up to $900 per calendar year)</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)</td>
<td></td>
<td>X</td>
<td>X</td>
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<td>Pest control (up to 9 units per calendar year)</td>
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B. Exclusions

BlueCare Tennessee makes the exclusion list available through this Manual (see Section IV. Benefits).

_Note: The Division of TennCare is solely responsible for the addition or deletion of any service or supply._


_Note: Providers are encouraged to routinely view the most current Exclusions list available on the Division of TennCare’s website. (See above TennCare Rules Web address._

C. Consumer Direction

Each CHOICES Member assessed to need specified types of HCBS including attendant care, personal care, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction is given the opportunity to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

A Consumer-Directed Worker is an individual who has been hired by a CHOICES Member participating in consumer direction of eligible CHOICES HCBS or his/her representative to provide one or more eligible CHOICES HCBS to the Member. The Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the Member.

CHOICES Members also have the option to direct and supervise a paid Consumer Directed Worker delivering eligible CHOICES HCBS in the performance of self-directed health care tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather health care-related duties and functions (such as administration of medications) that a CHOICES Member participating in consumer direction may elect to have performed by a Consumer-Directed Worker as part of the delivery of eligible CHOICES HCBS he/she is authorized to receive. Self-directed health care tasks are limited to the administration of oral, topical and inhalant medications.

D. Money Follows the Person (MFP)

Money Follows the Person (MFP) is a federal grant program that assists Medicaid-eligible individuals residing in a nursing facility in transitioning to a residential setting as a Group 2 Member in order to receive long-term services and supports. Members must be Medicaid-eligible, have been in a nursing facility or other qualified institution for at least ninety (90) days and are moving to a qualified residence (home or community setting) in the CHOICES program. Member participation in MFP is voluntary. Members are simultaneously enrolled in MFP and CHOICES.

Each MFP participant will have a Care Coordinator who works with individuals enrolled in CHOICES. Members will receive the CHOICES Home and Community Based Services that the member and Care Coordinator determine are needed. Please contact your Provider Network Manager for detailed program participation information.
IV. Care Coordination

A. Person-Centered Support Plan (PCSP)

The Person-Centered Support Plan (PCSP) is developed by the Care Coordinator taking into consideration the needs of the Member identified during an assessment, the support plan to address those needs, the facilitation of the plans and advocacy for the Member.

The assessment will consist of the Care Coordinator gathering relevant, comprehensive information and data required for the CHOICES Member’s comprehensive assessment and obtaining information by interviewing the Member, caregiver, and family. When indicated, the primary care Physician/Provider or Physician specialist, other Members of the health care team and other appropriate individuals as approved by the Member may also be interviewed. The Care Coordinator utilizes formal assessment tools prior approved by TennCare and in accordance with protocols specified by TennCare, telephonic assessment strategies, electronic communication, and/or other efficient modes of communication in addition to face-to-face visits as a means to perform careful evaluation of the CHOICES Member’s situation.

Assessment is important for the Care Coordinator to gather information concerning the Member’s health behaviors, cultural influences, socio-economics and behavioral health information related to the current or proposed PCSP to identify potential barriers, clarify or determine realistic goals and objectives, and seek appropriate alternatives for the Member. The Care Coordinator should recognize the importance of the Member’s involvement in a successful assessment process and should provide and encourage opportunities for the Member to communicate and collaborate with the Care Coordinator or any member of the Member’s health care team.

For new Members in CHOICES Group 1 receiving services in a nursing facility, the Care Coordinator will conduct the initial face-to-face visit within thirty (30) calendar days of enrollment notification. For CHOICES Group 2 and Group 3, the Care Coordinator will conduct the initial face-to-face visit within ten (10) business days of receipt of a CHOICES referral or new Member enrollment notification. The Nursing Facility (NF) Provider PCSP will be reviewed by the Care Coordinator, and supplemented as necessary. When the Care Coordinator is informed or becomes aware of a Member’s desire to transition from the nursing facility to the community, the Care Coordinator will perform a transition screening and assessment, which will include the Member’s potential for and interest in transition to the community. If the Member is found to be appropriate for transition to the community, the Care Coordinator will work with the Member to create a transition plan and initiate the transition as needed. If the Member is not found appropriate, the Care Coordinator will attempt to identify targeted strategies related to improving the Member’s health, functional, or quality of life outcomes and increasing and/or maintaining functional abilities. The Care Coordinator will coordinate with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the Member. In all cases, the BlueCare Tennessee CHOICES Care Coordinator remains the primary contact for Member interactions. The Care Coordinator will conduct at a minimum semi-annual visits and conduct a review of the Nursing Facility Provider PCSP and additional needs assessments as necessary.

CHOICES Group 1

For Members in CHOICES Group 1, the Member’s Care Coordinator may:

- rely on the Provider PCSP developed by the nursing facility for service delivery instead of developing a PCSP for the Member, if the Care Coordinator agrees the nursing facility Provider PCSP meets the Member’s needs; or
- supplement the Provider PCSP as necessary with the development and implementation of targeted strategies to improve health, functional, or quality of life outcomes (e.g., related to Population Health Management services or pharmacy management) or to increase and/or maintain functional abilities.
- The Member’s Care Coordinator will ensure that approved specialized services are part of the PCSP developed for the Member and will coordinate with the facility to ensure the services are delivered.
Care Coordinators will participate in the nursing facility’s care planning process and advocate for the Member.

The Member’s Care Coordinator/care coordination team is responsible for coordination of the Member’s physical health, behavioral health, and long-term service and support needs, which will include coordination with the nursing facility as necessary to facilitate access to physical health and/or behavioral health services needed by the Member and to help ensure the proper management of the Member’s acute and/or chronic physical health or behavioral health conditions, including services covered by BlueCare Tennessee that are beyond the scope of the nursing facility services benefit.

**CHOICES Groups 2 and 3**

For Members in CHOICES Groups 2 and 3, the Care Coordinator will coordinate and facilitate a care planning team that includes the Member and the Member’s Care Coordinator. The Care Coordinator will include or seek input from other individuals such as the Member’s representative or other persons authorized by the Member to assist with needs assessment and care planning activities.

Care Coordinators will consult with the Member’s PCP, specialists, behavioral health Providers, other Providers and interdisciplinary team experts, as needed when developing the PCSP.

The Care Coordinator will verify that the decisions made by the care planning team are documented in a written, comprehensive PCSP.

The PCSP developed for CHOICES Members in Groups 2 and 3 prior to initiation of CHOICES HCBS include:

- Pertinent demographic information regarding the Member including the name and contact information of any representative and a list of other persons authorized by the Member to have access to health care (including long-term services and supports) related information and to assist with assessment, planning, and/or implementation of health care (including long-term services and supports);
- Care, including specific tasks and functions that will be performed by family members and other caregivers;
- Home health, private duty nursing, and long-term services and supports the Member will receive from other payer sources including the payer of such services;
- Home health and private duty nursing that will be authorized by BlueCare Tennessee;
- CHOICES HCBS that will be authorized by BlueCare Tennessee, including:
  - The amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided; and
  - The schedule at which such care is needed.
- A detailed back-up plan for situations when regularly scheduled HCBS Providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and will include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; and
- For CHOICES Group 2 Members, the projected TennCare monthly and annual cost of home health and private duty nursing identified above, and the projected monthly and annual cost of CHOICES HCBS specified above; for CHOICES Group 3 Members, the projected total cost of CHOICES HCBS specified above, excluding the cost of minor home modifications, home health and private duty nursing.
- Description of the Member’s current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the Member’s physical, behavioral and functional needs;
- Description of the Member’s physical environment and any modifications necessary to ensure the Member’s health and safety;
- Description of medical equipment used or needed by the Member (if applicable);
- Description of any special communication needs including interpreters or special devices;
- A description of the Member’s psychosocial needs, including any housing or financial assistance needs which could impact the Member’s ability to maintain a safe and healthy living environment;

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☑ Goals, objectives and desired health, functional, and quality of life outcomes for the Member;
☑ Description of other services that will be provided to the Member, including:
  - Covered physical and behavioral health services that will be provided by BlueCare Tennessee to help the Member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence;
  - Other social support services and assistance needed in order to ensure the Member’s health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement; and
  - Any non-covered services including services provided by other community resources, including plans to link the Member to financial assistance programs including housing, utilities and food as needed.
☑ Relevance information from the Member’s individualized treatment plan for any Member receiving behavioral health services that is needed by a long-term services and supports Provider, caregiver or the Care Coordinator to ensure appropriate delivery of services or coordination of services;
☑ Relevance information regarding the Member’s physical health condition(s), including treatment and medication regimen that is needed by a long-term services and supports Provider, caregiver or the Care Coordinator to ensure appropriate delivery of services or coordination of care;
☑ Additional information for Members who elect consumer direction of eligible CHOICES HCBS, including whether the Member requires a representative to participate in consumer direction and the specific services that will be consumer directed;
☑ Any steps the Member and/or representative should take in the event of an emergency that differ from the standard emergency protocol;
☑ A disaster preparedness plan specific to the Member; and
☑ The Member’s TennCare eligibility end date.

The Member’s Care Coordinator/care coordination team will ensure that the Member reviews, signs and dates the PCSP as well as any updates, as necessary. The Care Coordinator shall also sign and date the PCSP, along with any updates, as specified by TennCare. The Provider, also, receives copies of the approved PCSP; their acknowledgment by electronic mechanism or through proxy is obtained, indicating their receipt and understanding of all relevant service provisions they will be providing to the Member.

When the refusal to sign is due to a Member’s request for additional services, (including requests for a different type or an increased amount, frequency, scope, or duration of services than what is included in the PCSP) BlueCare Tennessee will, in the case of a new PCSP, authorize and initiate services in accordance with the PCSP. In the case of an annual or revised PCSP, BlueCare Tennessee will ensure continuation of at least the level of services in place at the time the annual or revised PCSP was developed until a resolution is reached, which may include resolution of a timely filed appeal. BlueCare Tennessee will not use the Member’s acceptance of services as a waiver of the Member’s right to dispute the PCSP or as cause to stop the resolution process.

When the refusal to sign is due to the inclusion of services that the Member does not want to receive, either in totality or in the amount, frequency, scope or duration of services in the PCSP, the Care Coordinator will modify the risk agreement to note this issue, the associated risks and the measures to mitigate the risks. The risk agreement will be signed and dated by the Member or his or her representative and the Care Coordinator. In the event the Care Coordinator determines that the Member’s needs cannot be safely and effectively met in the community without receiving these services, BlueCare Tennessee may request that it no longer provide long-term services and supports to the Member.

The Member’s Care Coordinator/care coordination team will provide a copy of the Member’s completed PCSP, including any updates, to the Member, the Member’s representative, and the Member’s community residential alternative Provider, as applicable. The Member’s Care Coordinator/care coordination team will provide copies of the Provider PCSP to other Providers authorized to deliver care, and will ensure that Providers are informed in writing of all relevant information needed to ensure the provision of quality care for the Member and to help ensure the Member’s health, safety and welfare, including the tasks and functions to be performed.
In the event the Member has had a significant change, The Member’s Care Coordinator will assess the Member’s needs and update the PCSP, as appropriate, within five (5) business days of learning of the significant change. The Member’s Care Coordinator will authorize and initiate HCBS from the new PCSP within five (5) days from the Member signing the new PCSP.

The Member’s Care Coordinator will inform each Member of his or her eligibility end date and educate Members regarding the importance of maintaining TennCare CHOICES eligibility, that eligibility must be re-determined at least once a year, and that Members receiving CHOICES HCBS will be contacted by TennCare near the date a re-determination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

B. Authorizations

BlueCare Tennessee does not require home and community based services to be ordered by a treating Physician, but the Care Coordinator may consult with the treating Physician as appropriate regarding the Member’s physical health, behavioral health, and long-term service and support needs and in order to facilitate communication and coordination regarding the Member’s physical health, behavioral health, and long-term services and supports.

For Members enrolled in CHOICES Group 2 and Group 3, the Care Coordinator will be responsible for ensuring services are authorized and initiated as outlined in the Member’s PCSP within ten (10) business days of notice of Member’s enrollment with the exception of the following:

1. Assistive Technology – thirty (30) days
2. Pest Control – sixty (60) days
3. Minor Home Modifications – ninety (90) days
4. Respite – In accordance with the Member’s needs as specified in the PCSP

Services must be provided in accordance with the approved PCSP, within the Member’s service schedule, and be authorized, as applicable, in order to receive reimbursement for the services rendered. The service authorization will include the amount, frequency and duration of each service to be provided and the schedule at which such care is needed, as applicable, the requested start date, and other relevant information as needed.

Enhanced Respiratory Care Authorization

BlueCare Tennessee reimburses Enhanced Respiratory Care (ERC) through an authorization process when services are delivered at a nursing facility certified for both Medicaid and Medicare for the provision of NF/SNF that meets the requirements set forth in Tennessee Rules. Enhanced Respiratory Care reimbursement specifies levels for Ventilator Weaning, Chronic Ventilator Care, and Tracheal Suctioning, including sub-acute and secretion management and are reimbursed to certified facilities in accordance to services they are authorized to perform, and based upon their level of quality performance at the time of service.

Each level Enhanced Respiratory Care reimbursement shall be an add-on payment to the NF’s established Level 2 per diem rate (or the NF’s blended per diem rate, when established). The amount of the NF’s add-on payment to the facility’s established level 2 per diem rate (or the NF’s blended per diem rate, when established) for each of the specified levels of reimbursement, shall be based upon the facility’s performance on quality outcome and technology measures pursuant to a methodology to apply such measures and benchmarks to each of the specified levels of enhanced care reimbursement. Nursing Facilities that perform higher levels of quality care, and produce better patient outcomes will be eligible to be in higher tiers, thus will receive a higher rate of reimbursement. Nursing facilities that provide enhanced respiratory care services and perform poorly will be categorized in the lower tiered levels and receive lower rates of reimbursement.
A Nursing Facility contracted with one or more TennCare MCOs to receive Enhanced Respiratory Care Reimbursement must be operating in compliance with Department of Health rule 1200-08-06-(12) in order to be eligible for Enhanced Respiratory Care Reimbursement. The rule requires nursing facilities to ensure residents’ rights are established and deployed. The facility must implement written policies and procedures that set forth the protection and preservation of dignity, individuality, and to the extent medically feasible, independence. The residents and their families or other representatives must be fully informed and documentation must be maintained in the resident’s files each of the rights outlined in the rule.

In addition, the nursing facility shall provide attestation of its compliance with each requirement specified or shall submit a plan of correction regarding how it will achieve compliance with any condition not currently specified in 1200-08-06(12) no later than January 1, 2017, and as of January 1, 2017, must be operating in compliance with all conditions specified.

Effective July 1, 2018, there will no longer be distinct Level 1 and Level 2 Nursing Facility rates in the CHOICES program. Under the new reimbursement system, each NF will have a blended quality- and acuity-adjusted per diem rate which takes into account the case mix of residents in the facility and the facility’s quality performance in QuILTSS.

The new TennCare Rule 1200-13-02, (available at http://publications.tnsosfiles.com/rules_filings/05-01-18.pdf) which operationalizes the new reimbursement system becomes effective on July 30, 2018. Thus, the Nursing facility reimbursement rate changes will be implemented August 1, 2018, with an effective date of July 1, 2018.

Beginning July 1, 2018, Skilled Services may still be requested on the PAE for purposes of calculating the acuity score for level of care determination, but not for purposes of reimbursement (other than Enhanced Respiratory Care for contracted ERC facilities). Enhanced Respiratory Care (ERC) Reimbursement submission and approval processes will not change except that ERC rates will be an add-on to the NF’s blended per diem rate. TPAES will be streamlined for ERC requests.

For dates of service July 1, 2018, and after NFs will bill for CHOICES residents using their Medicaid Level 2 ID and revenue code 192 ONLY for ERC. Providers must bill with the correct Medicaid ID and revenue code in order to be reimbursed.

As a reminder, Level 1 bed hold days are no longer covered and should not be billed effective 7/1/18.

Add-on rates effective July 1, 2016:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Ventilator Weaning (Add-on Rate)</th>
<th>Weaning</th>
<th>Sub-Acute Tracheal Suctioning</th>
<th>Secretion Management Tracheal Suctioning</th>
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Enhanced Respiratory Care Reimbursement shall be provided only for services authorized and delivered in a facility operating in compliance with conditions of reimbursement for Enhanced Respiratory Care specified in 1200-13-01-13(05), and in a bed specifically licensed for such purpose, as applicable. A Nursing Facility shall not be eligible for Enhanced Respiratory Care Reimbursement if it does not meet the conditions for reimbursement specified in 1200-13-01-13(05), or for any Enhanced Respiratory Care services provided in excess of the facility’s licensed capacity to provide such services, regardless of payer source. Enhanced Reimbursement is only available if accurate quality measurement data is submitted monthly, and submitting false information will subject the Nursing Facility to applicable State and Federal laws pertaining to false claims.
Furthermore, nursing facilities providing Ventilator Weaning or Chronic Ventilator Care services and NFs receiving short-term reimbursement at the Sub-Acute Tracheal Suctioning rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention, shall also meet or exceed the following minimum standards:

1. The NF shall ensure that medical direction of all Ventilator Weaning, Chronic Ventilator Care, and Sub-Acute Tracheal Suctioning services is provided by a physician licensed to practice in the State of Tennessee and board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.

2. The NF shall ensure that medical direction of all Ventilator Weaning, Chronic Ventilator Care, and Sub-Acute Tracheal Suctioning services is provided by a physician licensed to practice in the State of Tennessee and board certified in pulmonary disease or critical care medicine as recognized by either the American Board of Medical Specialties or American Osteopathic Association, as applicable.

A licensed respiratory care Practitioner as defined by T.C.A. § 63-27-102(7), shall be on site in the ventilator care unit twenty-four (24) hours per day, seven (7) days-per-week to provide:

(i) Ventilator care;
(ii) Administration of medical gases;
(iii) Administration of aerosol medications; and
(iv) Diagnostic testing and monitoring of life support systems.

3. The NF shall ensure that an appropriate individualized POC is prepared for each resident receiving Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning. The POC shall be developed with input and participation from the medical director of the NF’s Enhanced Respiratory Care program.

4. The NF shall establish admissions criteria to ensure the medical stability of ventilator-dependent residents prior to transfer from an acute care setting. The NF shall maintain documentation regarding the clinical evaluation of each resident who will receive Enhanced Respiratory Care for appropriateness of placement in the facility prior to admission.

5. End tidal carbon dioxide (etCO2) or transcutaneous monitoring of carbon dioxide and oxygen (tcCO2) and continuous pulse oximetry measurements shall be available for all residents receiving Chronic Ventilator Care and provided based on the needs of each resident. For residents receiving Ventilator Weaning or Sub-Acute Tracheal Suctioning, end tidal Carbon Dioxide (etCO2) and pulse oximetry measurements shall be provided no less than every four (4) hours, and within one (1) hour following all vent parameter changes.

6. An audible, redundant external alarm system shall be connected to emergency power and/or battery back-up and located outside the room of each resident who is ventilator-dependent for the purpose of alerting staff of resident ventilator circuit disconnection or ventilator failure.

7. Ventilator equipment (and ideally physiologic monitoring equipment) shall be connected to back-up generator power via clearly marked wall outlets.

8. Ventilators shall be equipped with adequate back-up provisions, including:

(i) Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;
(ii) Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery operated concentrators);
(iii) At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy; and
(iv) A minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times.
9. The NF shall be equipped with current ventilator technology to encourage and enable maximum mobility and comfort, ideally weighing less than fifteen (15) pounds with various mounting options for portability (e.g., wheelchair, bedside table, or backpack).

10. The facility shall have an emergency preparedness plan specific to residents receiving Enhanced Respiratory Care which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

11. The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving Enhanced Respiratory Care (i.e., Ventilator Weaning, Chronic Ventilator Care, or Sub-Acute Tracheal Suctioning).

The previous listed standards are not applicable for **Secretion Management Tracheal Suctioning** Reimbursement; however, the Nursing facility must meet standards as noted below for Secretion Management Tracheal Suctioning Reimbursement.

NFs receiving Secretion Management Tracheal Suctioning Reimbursement shall meet or exceed the following minimum standards:

1. A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102(7), shall be on site a minimum of weekly to provide:
   (i) Clinical Assessment of each resident receiving Secretion Management Tracheal Suctioning (including Pulse Oximetry measurements);
   (ii) Evaluation of appropriate humidification;
   (iii) Tracheostomy site and neck skin assessment;
   (iv) Care plan updates; and

2. The NF shall ensure that an appropriate individualized POC is prepared for each resident receiving Secretion Management Tracheal Suctioning. The POC shall be developed with input and participation from a licensed respiratory care practitioner as defined by T.C.A. § 63-27-102(7). (Medical direction, including POC development and oversight for persons receiving Sub-Acute Tracheal Suctioning shall be conducted with input and participation from the medical director of the NF’s Enhanced Respiratory program.

3. The NF shall establish admissions criteria which meet the standard of care to ensure the medical stability of residents who will receive Secretion Management Tracheal Suctioning prior to transfer from an acute care setting. The NF shall maintain documentation regarding the clinical evaluation of each resident who will receive Secretion Management Tracheal Suctioning for appropriateness of placement in the facility prior to admission.

4. Pulse oximetry measurements shall be provided at least daily with continuous monitoring available, based on the needs of each resident. For any resident being weaned from the tracheostomy, the following shall be provided:
   (i) Continuous pulse oximetry monitoring; and
   (ii) End tidal Carbon Dioxide (etCO2) measurements at least every 12 hours. Transcutaneous (tcCO2) shall not be appropriate for intermittent monitoring.

5. Mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy shall also be available for secretion management, as appropriate for the needs of each resident.

6. Oxygen equipment shall be connected to back-up generator power via clearly marked wall outlets.
7. Adequate back-up provisions shall be in place including:
   (i) Sufficient emergency oxygen delivery devices (i.e. compressed gas or battery operated concentrators); and
   (ii) At least one (1) battery operated suction device available per every eight (8) residents on mechanical ventilation or with a tracheostomy.

8. The facility shall have an emergency preparedness plan specific to residents receiving Secretion Management Tracheal Suctioning which shall specifically address total power failures (loss of power and generator), as well as other emergency circumstances.

9. The facility shall have a written training program, including an annual demonstration of competencies, for all staff caring for residents receiving Secretion Management Tracheal Suctioning which shall include (at a minimum) alarm response, positioning and transfers, care within licensure scope, and rescue breathing.

10. When a facility establishes a “Tracheostomy Unit” (i.e., accepts Tracheal Suctioning Reimbursement, including Sub-Acute and Secretion Management, for more than three (3) residents on the same day, the licensed respiratory care Practitioner as required and defined in T.C.A, § 63-27-102(7) shall be on site a minimum of daily for assessment, care management, and care planning of residents receiving Tracheal Suctioning.

11. A NF contracted with one or more TennCare MCOs to receive Secretion Management Tracheal Suctioning Reimbursement shall provide attestation of its compliance with each of the requirements:

   A licensed respiratory care practitioner as defined by T.C.A. § 63-27-102(7), shall be on site a minimum of weekly to provide:
   - Clinical Assessment of each resident receiving Secretion Management Tracheal Suctioning (including Pulse Oximetry measurements);
   - Evaluation of appropriate humidification;
   - Tracheostomy site and neck skin assessment;
   - Care plan updates; and

   When a facility has not established compliance, the facility shall submit a plan of correction regarding how it will achieve compliance no later than January 1, 2017, and shall maintain compliance on a continuous basis thereafter. As of January 1, 2017, a NF must be operating in compliance with all of the conditions specified in order to be eligible for Secretion Management Tracheal Suctioning Reimbursement.

   Additionally, in order to be approved by the Division of TennCare reimbursed care in a Nursing Facility at the Secretion Management Tracheal Suctioning rate of reimbursement, a Member must have a functioning tracheostomy and a copious volume of secretions, and require either:
   (i) Invasive tracheal suctioning, at a minimum, once every three (3) hours with documented assessment pre- and post-suctioning; or
   (ii) The use of mechanical airway clearance devices and/or heated high flow molecular humidification via the tracheostomy, at a minimum, three (3) times per day with documented assessment pre-and post.

12. The suctioning (or airway clearance, as applicable) must be required to remove excess secretions and/or aspirate from the trachea, which cannot be removed by the Applicant’s spontaneous effort. Suctioning of the nasal or oral cavity does not qualify for this higher level of reimbursement. An MCO may authorize, based on Medical Necessity, short-term payment at the Sub-Acute Tracheal Suctioning Enhanced Respiratory Care rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention during the post-weaning period which shall include documented progress in weaning from the tracheostomy.

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13. A PAE for Secretion Management Tracheal Suctioning Reimbursement shall be approved for no more than a period of thirty (30) days. Clinical review and approval of a new PAE shall be required for ongoing coverage, which shall include evaluation of clinical progress and the NF’s efforts to improve secretion management through alternative methods.

Required documentation:
- A history and physical performed within the last 365 days.
- Physician’s orders for enhanced respiratory care.
- Respiratory therapy documentation, including suctioning records and ventilator settings and measurements.
- Medical records supporting all functional limitations as reported in the PAE.

Upon approval of the PAE and specific ERC services by the Division of TennCare, the Member’s case will be escalated for an initial on-site evaluation by contracted respiratory therapists. Upon confirmation of the Member’s status, authorization for payment for enhanced respiratory care services rendered by the facility will be placed. The span of authorization will be based on enrollment date of the PAE and effective start and end dates of the ERC services approved within the PAE itself.

The respiratory therapists will subsequently perform monthly evaluations of the Member’s ERC status and report to BlueCare accordingly. Any changes in care required from month to month will impact the ongoing authorization for services as appropriate.

If the requested services are for ventilator weaning, the MCO Medical Director and team will determine Medical Necessity and authorize accordingly.

In addition, each Skilled Nursing Facility must submit a signed attestation when providing services to a TennCare Member deemed medically eligible for enhanced respiratory care (ERC) services. The signature of the Director of Nursing or appropriate designee is required and attests to the following:

- In accordance to Contract Risk Agreement 2.12.10.16 your Nursing Facility is licensed and certified by the Tennessee Department of Health to provide such specialized ERC, is certified by CMS for program participation, and is compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TENNCARE and will remain licensed while providing services to eligible Members.
- In accordance to Contract Risk Agreement 2.14.5.8 there is an available bed licensed by the Tennessee Department of Health specifically for the provision of ventilator weaning or chronic ventilator care or tracheal suctioning, as applicable, and that authorizing reimbursement at those rates for a member to receive those services would not cause the facility to exceed the number of beds licensed for such specialized ERC on any given day.

C. Coordination with State and Local Departments and Agencies

Care Coordinators coordinate with other state and local departments and agencies to verify that coordinated care is provided to Members. This includes, but is not limited to coordination with:

- Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for purposes of the integration and coordination of care;
- Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with Member groups and health service Providers;
- Tennessee Department of Human Services (DHS) and Department of Children’s Services (DCS) Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;
- Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (DEA) and to determine that school-based services for students with special needs are provided;
Tennessee Commission on Aging and Disability (TCAD) and Division of TennCare, Long Term Services and Supports Division for the purposes of coordinating care for Members requiring long-term services and supports;

Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service Provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.
V. Provider Roles and Responsibilities

A. Primary Care Provider

Primary Care Providers (PCPs) are responsible for the overall healthcare of CHOICES Members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all Medically Necessary and Covered Services;
- Initiating and/or authorizing referrals for specialty care;
- Monitoring the continuity of Member care services;
- Routine office visits for new and established Members;
- TennCare Kids services;
- Collaboration with the care coordinator;
- Hearing services including: screening test, pure tone audiology, air only audiology, pure tone audiometry and air only audiometry hearing services;
- Counseling and risk intervention, family planning;
- Immunizations;
- Administering and interpreting of health risk assessment instrument;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide Covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

B. Care Coordinator

The Care Coordinator is the individual who has primary responsibility for performance of care coordination activities for CHOICES Members. For CHOICES Members, the Member’s Care Coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term service and support Providers.

The Care Coordinator will:
1. for Groups 2 and 3, develop a Person-Centered Support Plan (PCSP) based on the Member’s needs;
2. for Groups 1, 2, and 3, review the PCSP to ensure that CHOICES services furnished are consistent with the nature and severity of the Member’s disability and to determine the appropriateness and adequacy of care and achievement of outcomes and objectives outlined in the PCSP;
3. develop a Safety Plan with the Member and appropriate caregivers. The Safety Plan must include, at a minimum, detailed and (reading level) appropriate instructions on who to contact in case of an emergency;
4. review with the Member and appropriate caregivers on a regular basis the Safety Plan and insure that all contact information is current;
5. be available by telephone through an answered office telephone during normal business hours (to be specified to Member);
6. be available by cell telephone/pager outside of normal business hours* (to be specified to Member); and
7. install appropriate voice message advice on its main office telephone system providing simple instructions for contacting appropriate authorities in emergency situations.
If a Member elects to transfer to a nursing facility, the Care Coordinator will assist with the process and will complete all necessary documents to facilitate the transfer.

*If the Care Coordination Department does not use a cell telephone/pager system outside of normal business hours, a contract must be implemented with an established emergency response center for after-hours telephone answering.

C. Long-Term Services and Supports Providers

Providers are responsible for providing CHOICES HCBS. Responsibilities associated with these services include, but are not limited to:

- Use of EVV system (process to monitor CHOICES HCBS using electronic visit verification (EVV) for the TennCare CHOICES program);
- Participation in the person-centered care planning process driven by the Member;
- Collaboration with the Care Coordinator to help ensure the plan is implemented timely and convenient for the Member;
- Notifying a Member’s Care Coordinator, as expeditiously as warranted by the Member’s circumstances, of any significant changes in the Member’s condition or care, hospitalizations, or recommendations for additional services;
- Monitoring and immediately addressing service gaps, including back-up staff;
- Conducting background checks on its employees, subcontractors, and agents, prior to providing services, in accordance with state law and TennCare policy;
- Investigating and reporting critical incidents; and
- Providing current financial solvency when providing Community Living Supports services.
VI. Provider Agreement Requirements

Each Provider agency must sign the TennCare Provider Agreement and a properly executed copy must be on file with the TennCare Provider Relations Division.

Definitions:

**Care Coordinator** - The individual who has primary responsibility for performance of care coordination activities for a CHOICES Member as specified in the Contractor Risk Agreement and meets the qualifications of the Contractor Risk Agreement.

**Care Coordination Team** - If an MCO elects to use a Care Coordination Team, the Care Coordination Team shall consist of a Care Coordinator and specific other persons with relevant expertise and experience who are assigned to support the Care Coordinator in the performance of care coordination activities for a CHOICES Member as specified in the Agreement (and in accordance with the Contractor Risk Agreement between BlueCare Tennessee and the State of Tennessee), but shall not perform activities that must be performed by the Care Coordinator, including needs assessment, development of the Person-Centered Support Plan (PCSP), and minimum Care Coordination contacts.

**CHOICES Member** – A TennCare Enrollee who: 1) has been enrolled by TennCare into CHOICES; and 2) is enrolled with BlueCare Tennessee under the provision of the Contractor Risk Agreement or the TennCareSelect Agreement.

**Electronic Visit Verification (EVV) System** – An electronic system which Provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor Member receipt of specified CHOICES and ECF CHOICES HCBS and which may also be utilized for submission of claims.

**Home and Community Based Services (HCBS)** – Services that are provided pursuant to Section 1915(c) waiver or the CHOICES program as an alternative to long-term services and supports in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are Covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES Member’s needs can be safely met in the community within his or her individual cost neutrality cap for Group 2 or expenditure cap for Group 3.

**Home and Community–Based Services (“HCBS” or “Services”)** – Services not Covered by Tennessee’s Title XIX state plan that are provided as an alternative to long-term services and supports in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID). HCBS does not include home health or private duty nursing services.

**Home and Community-Based Settings** – is integrated in and supports access to the greater community and provides opportunities to seek employment and work in competitive integrated settings, engagement in community life, and offers control of personal resources. It also offers the same access as others that do not receive Medicaid benefits.
Long-Term Services and Supports (LTSS) – The services of a nursing facility (NF), an Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID), or Home and Community Based Services (HCBS).

Medical Necessity and Medically Necessary – Medical Necessity and Medically Necessary as used in the Agreement shall have the same meaning contained in Tennessee Code Annotated Section 71-5-144 and TennCare Rule 1200-13-16.

Member – A TennCare Enrollee who: 1) has been enrolled by TennCare into CHOICES; and 2) is enrolled with BlueCare Tennessee under the provision of the Contractor Risk Agreement or the TennCareSelect Agreement.

PASRR – Preadmission Screening and Resident Review.

Person-Centered Support Plan (PCSP) – The process by which a Care Coordinator develops a care plan based on the needs of CHOICES Member identified during an assessment. It reflects the strengths of the Member to help ensure the delivery of services in a manner also reflecting personal preferences ensuring the health and welfare of the Member.

Person-Centered Planning – is driven by the Member and individuals chosen by the Member to provide necessary information and support to the individual to help ensure the individual directs the process to the maximum extent possible.

Provider Person-Centered Support Plan – A copy of the completed PCSP specific to the servicing Provider outlining contracted services approved for the CHOICES Member. The PCSP must be signed, dated and sent to BlueCare by the Provider indicating acceptance to provide the PCSP.

Provider – An institution, facility, agency, Physician, health care Practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished. Provider does not include consumer-directed workers; nor does Provider include the fiscal employer agent (FEA).

TennCareSelect Agreement – The Agreement between the State and BlueCare Tennessee whereby BlueCare Tennessee administers the State’s TennCare health plan, TennCareSelect.

TennCare CHOICES in Long-Term Services and Supports (CHOICES) – A program in which long-term services and supports for persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities, and who qualify for TennCare. Under this program, MCOs are responsible for the delivery and coordination of covered physical health, behavioral health, and long-term services and supports for CHOICES Members.

Pursuant to Amendment 22 (CHOICES) to the Contractor Risk Agreement (TennCareSelect) effective March 1, 2010, and Contractor Risk Agreement (BlueCare) effective August 1, 2010, for the West Grand Region and August 1, 2010, for the East Grand Region between TennCare and BlueCare Tennessee (also referred to as "MCO"), Provider must comply with the following TennCare Provider Agreement requirements for participation in CHOICES:

If the Provider is a nursing facility, it shall meet the minimum requirements specified in Section XII. Highlights of Provider Agreement in this Manual, subsection C: TennCare/Subcontractor Provider Agreement Requirements. In addition, the nursing facility (herein referred to as “Provider”) must also comply with the following:

1. Provider shall promptly notify BlueCare Tennessee and/or State entity as directed by TennCare, of a Member’s admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in the Member’s known circumstances and to notify BlueCare Tennessee, and/or State entity as directed by TennCare, prior to a Member’s discharge.
2. Provider shall provide advance written notice to BlueCare Tennessee before voluntarily terminating the agreement and specify the timeframe for providing such notice.

3. Provider shall notify BlueCare Tennessee immediately if Provider is considering discharging a Member. Provider must consult with the Member’s Care Coordinator to intervene in resolving the issue if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.

4. Provider shall notify the Member in writing prior to discharge in accordance with state and federal requirements.

5. Provider shall accept payment or appropriate denial made by BlueCare Tennessee (or, if applicable, payment by BlueCare Tennessee that is supplementary to the Member’s third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served.

6. Provider’s responsibilities and prohibited activities regarding cost sharing and patient liability are set forth in Sections A.2.6.7 and A.2.21.5, which include but is not limited to, collecting the applicable patient liability amounts from CHOICES Group 1 Members, notifying the Member’s Care Coordinator if there is an issue with collecting a Member’s patient liability, and making good faith efforts to collect payment.

7. Provider shall cooperate fully with BlueCare Tennessee in the completion and submission of the level of care assessment.

8. Provider shall notify BlueCare Tennessee of any change in a Member’s medical or functional condition that could impact the Member’s level of care eligibility for the currently authorized level of nursing facility services.

9. Provider shall comply with state and federal laws and regulations applicable to nursing facilities as well as any applicable federal court orders, including but not limited to those that govern admission, transfer and discharge policies.

10. Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable to all nursing facility residents, regardless of payor source, including that a Level I screening be completed prior to admission, a Level II evaluation be completed prior to admission when indicated by the Level I screening, and a review be completed based upon a significant physical or mental change in the resident’s condition that might impact the Member’s needs for or benefit from specialized services. Additionally, if specialized services are recommended on a Member’s PASRR, the Provider shall be required to confirm, in a manner specified by BlueCare, its willingness and ability to provide the specialized services.

11. Provider shall cooperate with BlueCare Tennessee in developing and implementing protocols as part of the MCO’s nursing facility diversion and transition plans (A.2.9.6.7) which shall, include, at a minimum, the nursing facility’s obligation to promptly notify BlueCare Tennessee upon admission or request for admission of an eligible Member regardless of payor source for the nursing facility stay; how the nursing facility will assist BlueCare Tennessee in identifying residents who may want to transition from nursing facility services to home and community-based care; Provider has an obligation to promptly notify BlueCare Tennessee regarding all such identified Members; and how the Provider will work with BlueCare Tennessee in assessing the Member’s transition potential and needs, and in developing and implementing a transition plan, as applicable.

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12. Provider should coordinate with BlueCare Tennessee in complying with the requirements in 42 CFR 483.75 regarding written transfer agreements and shall use contract Providers when transfer is medically appropriate, except as authorized by BlueCare Tennessee or for emergency services.

13. Provider shall have a file system designed and utilized to ensure the integrity of the Member’s personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations.

14. Provider must immediately notify BlueCare Tennessee of any change in its license to operate as issued by the Tennessee Department of Health, Department of Human Services, Department of Intellectual and Developmental Disabilities, or the Tennessee Department of Mental Health and Substance Abuse Services as well as any deficiencies cited during the federal certification process.

15. If Provider is involuntarily decertified by the Tennessee Department of Health, Department of Human Services, Department of Intellectual and Developmental Disabilities, or the Tennessee Department of Mental Health and Substance Abuse Services, or the Centers for Medicare and Medicaid Services, the Provider Agreement will automatically be terminated.

16. Provider is not required to have liability insurance in excess of TennCare requirements in effect prior to the implementation of CHOICES.

17. Provider Agreements shall be assigned from BlueCare Tennessee to the State, or its designee, at the State’s discretion upon written notice to BlueCare Tennessee and the affected Provider. Further, the Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of BlueCare Tennessee.

18. Any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse, Providers must report such grievances and shall be included in the non-discrimination reporting.

If the Provider is a CHOICES HCBS Provider, it shall meet the applicable minimum requirements specified in Section XII. Highlights of Provider Agreement, subsection C: TennCare/Subcontractor Provider Agreement Requirements. In addition, the CHOICES HCBS Provider (herein referred to as “Provider”) must also comply with the following:

1. Provider shall provide at least thirty (30) days advance notice to BlueCare Tennessee when the Provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member’s Care Coordinator to facilitate a seamless transition to alternate Providers.

2. In the event that a Provider change is initiated for a Member, regardless of any other provision in the Provider Agreement, the transferring Provider shall continue to provide services to the Member in accordance with the Member’s Person Centered Plan of Care (PCSP) until the Member has been transitioned to a new Provider, as determined by BlueCare Tennessee, or as otherwise directed by BlueCare Tennessee which may exceed thirty (30) days from the date of notice to BlueCare Tennessee.

3. Provider’s reimbursement shall be contingent upon the provision of services to an eligible Member in accordance with applicable federal and state requirements and the Member’s PCSP as authorized by BlueCare Tennessee and must be supported by detailed documentation of service delivery to support the amount of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the name of the
Member receiving the service, the name of the staff person who delivered the service, the
detailed tasks and functions performed as a component of each service, notes for other
caregivers (whether paid or unpaid) regarding the Member or his/her needs (as applicable),
and the initials or signature of the staff person who delivered the service.

4. Provider shall immediately report any deviations from a Member’s service schedule to the
Member’s Care Coordinator.

5. Provider shall use the electronic visit verification (EVV) system specified by BlueCare
Tennessee in accordance with BlueCare Tennessee’s requirements.

6. Upon acceptance by the Provider to provide approved services to a Member as indicated in
the Member’s PCSP, the Provider shall ensure that it has staff sufficient to provide the
service(s) authorized by BlueCare Tennessee in accordance with the Member’s PCSP,
including the amount, frequency, duration and scope of each service in accordance with the
Member’s service schedule.

7. Provider is required to provide back-up for its own staff if Provider is unable to fulfill its
assignment for any reason. Provider shall ensure that back-up staff meets the qualification for
the authorized service.

8. Provider is prohibited from requiring a Member to choose the Provider as a provider of
multiple services as a condition of providing any service to the Member.

9. Provider is prohibited from soliciting Members to receive services from the Provider, including (1)
Referring an individual for CHOICES screening and intake with the expectation that, should
CHOICES enrollment occur, the Provider will be selected by the Member as the service Provider; or
(2) communication with existing CHOICES Members via telephone, face-to-face or written
communication for the purpose of petitioning the Member to change CHOICES Providers; or (3)
communicating with hospitals, discharge planners or other institutions for the purposes of soliciting
potential CHOICES Members that should instead be referred to the person’s MCO.

10. Provider must comply with critical incident report and management requirements (see Section
A.2.15.7 of the Contractor Risk Agreement) and in accordance with TCA 71-6-103; TCA 37-1-403
and TCA 37-1-605.

11. Provider is not required to have liability insurance in excess of TennCare requirements in
effect prior to the implementation of CHOICES.

12. Provider is prohibited from altering in any manner official CHOICES or Money Follows the
Person (MFP) brochures or other CHOICES or MFP materials unless the MCO has submitted
a request to do so to TENNCARE and obtained prior written approval from TENNCARE in
accordance with Section A.2.17 of the Contractor Risk Agreement.

13. Provider is prohibited from reproducing for its own use the CHOICES or MFP logos unless the
MCO has submitted a request to do so to TENNCARE and obtained prior written approval from
TENNCARE in accordance with Section A.2.17 of the Contractor Risk Agreement.

14. The Provider Agreement with a CHOICES HCBS Provider to provide PERS, assistive
technology, minor home modifications, or pest control shall meet the requirements specified in
Sections A.2.12.9, A.2.12.10, and A.2.12.12 of the Contractor Risk Agreement except that
these Provider agreements shall not be required to meet the following requirements: Section
A.2.12.9.9 regarding emergency services; Section A.2.12.9.11 regarding delay in prenatal
care; Section A.2.12.9.12 regarding CLIA; Section A.2.12.9.38 regarding hospital protocols;
Section 2.12.9.40 regarding reimbursement of obstetric care; Section A.2.12.9.52.2 regarding
prior authorization of pharmacy; and Section A.2.12.9.53 regarding coordination with the
Pharmacy Benefits Manager (PBM).
15. The MCO is the only entity with the authority to accept CHOICES referrals and complete the screening and intake processes. HCBS Providers may not recruit or solicit potential or actual CHOICES Members.

16. Provider is not allowed to solicit potential and/or actual BlueCare and TennCare Select Members to choose them as their CHOICES Provider.

17. Provider is not allowed to solicit and recruit potential or actual CHOICES Members by doing the following:

- Visiting Provider offices and hospital discharge planners and indicating that CHOICES referrals should be made to the HCBS Provider agency and not to an MCO;
- Augmenting CHOICES brochures so that HCBS Provider information appears on the brochure or creating marketing materials that indicate that the Provider is a point of contact for the CHOICES Program;
- Referring people for CHOICES intake and screening and requesting to be present during the assessment; requesting updates on the status of the referral; or expecting the Member to select the agency as their Provider if enrolled in CHOICES; and
- HCBS Providers “screening and assessing” people for the CHOICES enrollment.

Providers that provide ECF CHOICES Community Living Supports (CLS) and/or Community Living Supports Family Model (CLS-FM) must comply with the following requirements:

- Residential Providers shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).
- Providers shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to Member placement.
- Providers with Provider-owned vehicles (including employee-owned vehicles used to transport Members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.
- Providers shall designate a staff member as an Incident Management Coordinator who shall be trained on critical incident processes by the CONTRACTOR as prescribed by TENNCARE. Such staff member shall be the Provider’s lead for critical incidents, be primarily responsible for tracking and analyzing critical incidents pursuant to Section A.2.15.7.1.2, and be the CONTRACTOR’s main point of contact at the Provider agency for critical incidents.
- Providers shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by the CONTRACTOR. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.
- Providers shall develop and maintain a grievance resolution process, which includes, but is not limited to the following: designation of a staff member as the grievance contact person; maintenance of a grievance log; and documentation and trending of grievance activity. The Provider’s policies and procedures concerning the grievance resolution process shall be available to the CONTRACTOR upon request.
As applicable, Providers providing assistance to Members with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a Physician’s orders. Such Providers shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to Members when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement prevention strategies.

Providers shall develop and maintain policies approved by the CONTRACTOR that ensure Members are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:

- Ensuring Members/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable; Soliciting Member/representative and family feedback on Provider services; Ensuring the Member/representative has 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, if applicable; Supporting the Member in pursuing employment goals; and
- Only restricting Members’ rights as provided in the Member’s person-centered support plan.
- Residential Providers shall develop and maintain policies to ensure that Members have good nutrition while being allowed to exercise personal choice and those Members’ dietary and nutritional needs are met.
- Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that Provider staff have all required licensure and certification. Additionally, all Providers shall ensure that staff receive ongoing supervision consistent with staff job functions.
- Providers shall also ensure that the composition of the Provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the Provider serves and is representative of the people served.
- Residential Providers shall have policies and procedures to manage and protect Members’ personal funds that comport with all applicable TennCare policies, procedures and protocols.
- Providers shall agree to carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following.
- Workers’ Compensation/Employers’ Liability (including all States’ coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers’ liability.
- Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.
- Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00).
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VII. Provider Contracting/Credentialing

BlueCare Tennessee’s CHOICES program for Long Term Services and Supports (LTSS) has a process for credentialing and re-credentialing long-term service and support Providers. CHOICES ensures that its process, as applicable, meets the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, BlueCare Tennessee /CHOICES ensure that all long-term service and support Providers, including those credentialed/re-credentialed in accordance with NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations (MCOs), meet applicable State requirements, as specified by TENNCARE in State Rule, the Contractor Risk Agreement (CRA), or in policies or protocols.

Credentialing occurs initially during the application process for any Provider applying to participate in the CHOICES Network. Once a Provider is approved to participate in the network, they must be re-credentialed based on the service types each Provider provides. For ongoing CHOICES Home and Community Based Service (HCBS) Providers, they must be re-credentialed at least annually: Adult Day Care, Assisted Care Living Facility, Home Delivered Meals, Personal Care Services, Attendant Care, In-Home Respite, Personal Emergency Response System (PERS), and Adult Care Home. All other CHOICES HCBS Providers (pest control, in-patient respite, minor home modifications, and assistive technology) must be re-credentialed, at a minimum, every three (3) years.

CHOICES Providers that are contracted and enrolled in the network must be compliant with the HCBS Settings Rule and Person-Centered Planning to ensure Medicaid-funded HCBS are provided in settings that are non-institutional in nature. BlueCare ensures that contracted Providers deploy services that reflect Member needs, preferences, and goals. Through credentialing of first time Providers, and recredentialing of established Providers, BlueCare ensures that HCBS settings core indicators are met and sustained. The standards that are measured and are requirement for compliance, network entrance and retention are:

1. **Integration** in the greater community.
2. **Choice** of service settings and Providers that provide the services in the setting.
3. **Rights** to privacy, dignity, respect and freedom from coercion.
4. **Independence** that optimizes personal initiative and autonomy.

Compliance for the HCBS Setting Rule is measured during the mandatory credentialing schedule and conducted on-site visit. Providers must demonstrate ongoing compliance to these rules and confirm with signature through attestation on the Standards Assessment and Documentation Review Tool.

Credentialing of LTSS Providers shall include the collection of required documents, including ownership and disclosure statements, and verification that the Provider:

1. Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TENNCARE policies or protocols;
2. Attained an acceptable outcome for recent inspections or monitoring from licensing agencies as applicable;
3. Is not excluded from participation in the Medicare or Medicaid programs;
4. Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE;
5. Possesses General and/or Professional Liability insurance with acceptable limits;
6. Has policies and processes in place to conduct and evaluate, in accordance with federal and state law and rule and TENNCARE policy, criminal background checks, which shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee...
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Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective
employees who will deliver CHOICES HCBS and to document these in the worker’s employment
record; Additionally, has policies and procedure to check the LEIE monthly on an ongoing basis
for each worker; also has within the policy that screening of employees and contractors occur prior
to the performance of their duties and on an ongoing monthly basis to determine whether any of
them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health
care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or
contract with an individual or entity that has been excluded or debarred. The Provider shall also be
required to have an individual assessment policy for assessing potential employees whose
criminal background check reveals past criminal conduct of the kind not subject to exclusion or
debarment by state and federal law. The Provider shall be required to immediately report to
BlueCare Tennessee any exclusion information discovered. The Provider shall be informed by
BlueCare Tennessee that civil monetary penalties may be imposed against Providers who employ
or enter into contracts with excluded individuals or entities to provide items or services to
TennCare Members;

7. Has a process in place to provide and document initial and ongoing education to its employees
who will provide services to CHOICES Members that includes, at a minimum:
   ➢ Caring for Elderly and Disabled population;
   ➢ Abuse, neglect and exploitation prevention, identification and reporting;
   ➢ Critical incident identification and reporting;
   ➢ Documentation of service delivery;
   ➢ Deficit Reduction Act information regarding False Claim Act and detecting fraud, waste and
     abuse;
   ➢ Community Living Supports;
   ➢ Use of the EVV System; and
   ➢ Any other training requirements specified by TENNCARE in State Rule, or in policies or
     protocols; and

8. Has policies and processes in place to ensure:
   ➢ Compliance with BlueCare Tennessee’s critical incident reporting and management
     process;
   ➢ Appropriate use of the EVV system;
   ➢ Documentation, retention and disclosure of enrollee specific data;
   ➢ Documentation, retention and disclosure of service delivery;
   ➢ Deficit Reduction Act: False Claim Act and detecting fraud, waste and abuse;
   ➢ Community Living Supports; and
   ➢ Compliance with the Person-Centered Planning and HCBS Setting Rule.

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, LEIE checks, training requirements, critical incident reporting and
management, and use of the EVV.

For both credentialing and re-credentialing processes, CHOICES staff shall conduct a site visit. If the
Provider is located out of state, BlueCare Tennessee CHOICES may waive the site visit and perform a
documentation audit in lieu of the on-site visit documenting the reason in the Provider file. During the site
visits conducted for each CHOICES HCBS Provider type, BlueCare Tennessee will document and verify
compliance with all requested documentation. The tools used to identify potential deficiencies during the
credentialing and re-credentialing process include, but are not limited to, the following:

   ➢ BlueCare/TennCareSelect application
   ➢ CHOICES Rep Checklist
   ➢ CHOICES Enrollment Checklist
   ➢ Credential Statement of Attestation for Organizational Providers
   ➢ Standards Assessment; and Documentation Review Form

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If documents are not available at the time of the on-site audit, BlueCare Tennessee Provider Network Manager records the missing documents in the comment section of the CHOICES Site Visit Report. The Provider will be instructed to provide the missing documentation and of the obligation to supply the documentation by the due date established at the time of the on-site visit. The Provider may submit documents in the mutually agreed upon manner to include: e-mail, fax, mail or hand-delivery.

If required documents are not submitted timely and/or not acceptable:

- New Providers/initial credentialing: the contract process will end.
- Existing Providers will be placed on a Process Discontinuation Plan and receive a formal letter with a future termination date and re-credentialing will not be granted until all requirements are met.

If during the site visit any deficiencies are identified, CHOICES will require the Provider to correct the deficiency and may request the Provider submit a formal corrective action plan (CAP) that addresses the deficiency. Ongoing monitoring of that CAP will continue until all deficiencies have been adequately addressed and are no longer deficient. While a CAP could be requested for any deficiency related to VHSP’s policies and procedures for credentialing and re-credentialing, it could include any time a Provider does not meet CHOICES minimum requirements and/or deficiencies are identified related to the Provider’s policies, procedures, training and reporting processes.

BlueCare Tennessee’s CHOICES HCBS Credentialing Committee is responsible for reviewing and approving all initial credentialing and re-credentialing requests. The committee will take into account all information obtained during the credentialing or re-credentialing process to make a final decision. The committee will also review any findings or deficiencies along with an evaluation of the Provider’s corrective actions identified during the credentialing or re-credentialing process to aid in the decision making process. The committee may also take into account any additional grievances against the Provider or performance concerns that have been identified during the course of a Provider’s contract with CHOICES.

The BlueCare Tennessee Provider contract permits either party to terminate the Provider Agreement or any applicable network Attachment with sixty (60) days prior written notice. Final decisions are determined via committee member vote and outcomes are documented in the committee meeting minutes. BlueCare Tennessee furnishes written notification to the Providers regarding the status of the credentialing or re-credentialing process. At a minimum, BlueCare Tennessee shall re-verify monthly that each HCBS Provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

**Credentialing Requirements for CHOICES Providers**

**Adult Day Care (recredential every 3 years)**
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

**Assistive Technology (recredential every 3 years)**
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application
Assisted Care Living Facility (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Community Living Supports (CLS) (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit (including all CLS requirement and training)
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application
- Current signed copy of Financial Solvency Documentation
- 2.5 to 2.99 = CLS Provider is approved and must submit quarterly Z-score results with attestation
- Greater than 2.99 = CLS Provider is approved and will submit annual Z-score with attestation

Home Delivered Meals (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit - only if company is within the state of Tennessee - waived if location outside TN
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

In-Home Respite (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Inpatient Respite (recredentialed every 3 years)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Minor Home Modifications (recredentialed every 3 years)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application
Personal Care Services (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Attendant Care (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Personal Emergency Response System (PERS) (recredentialed annually)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit - only if company is within the state of Tennessee - waived if located outside Tennessee
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application

Pest Control (recredentialed every 3 years)
- License to practice in accordance to Attachment A
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure statement
- Site visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the correctness of the application
### HCBS Credentialing (CHOICES Program) - Attachment A

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCBS Providers:</strong> Personal care services, personal care attendant, In Home Respite</td>
<td>Personal Support Services Agency (PSSA) or Professional Support Services Facility, Home Health Agency or Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>PSSA or Home Health Agency</td>
</tr>
<tr>
<td><strong>Adult Day Care</strong></td>
<td>&quot;Adult Habilitation Day-MR&quot; (mental retardation) license from Department of Intellectual &amp; Developmental Disabilities (DIDDS) or Adult Day Care License from Department of Human Services</td>
</tr>
<tr>
<td><strong>Assisted Care Living Facility</strong></td>
<td>Assisted Care Living Facility (ACLF) or Nursing Home Facility</td>
</tr>
<tr>
<td><strong>Inpatient Respite</strong></td>
<td>ACLF or Nursing Home Facility</td>
</tr>
<tr>
<td><strong>Community Living Supports</strong></td>
<td>&quot;Adult Habilitation Day-MR&quot; (mental retardation) license from Department of Intellectual &amp; Developmental Disabilities (DIDDS)</td>
</tr>
<tr>
<td><strong>Assistive Technology</strong></td>
<td>DME license or other retail/wholesale supplier business license</td>
</tr>
<tr>
<td><strong>Home Delivered Meal</strong></td>
<td>ADC, Nursing Home, ACLF, Hospital, Home for the Aged, Residential Hospice, State Dept. of Agriculture (food processing facilities who deliver pre-packaged meals out of state) *PSSA allowed for providers who only deliver meals</td>
</tr>
<tr>
<td><strong>Pest Control</strong></td>
<td>TN Dept. of Agriculture (pest control charter)</td>
</tr>
<tr>
<td><strong>Personal Emergency Response System</strong></td>
<td>Nursing Home, Hospital or general business license, FCC &amp; UL certifications (if provided)</td>
</tr>
<tr>
<td><strong>Minor Home Modifications</strong></td>
<td>Service Agency, Building supplier, contractor, carpenter, craftsman or DME supplier</td>
</tr>
<tr>
<td><strong>Adult Care Home</strong></td>
<td>Adult Care Home license from Department of Health</td>
</tr>
</tbody>
</table>

Sample copies of the CHOICES Provider Standard Assessment and Documentation Review Form and Statewide HCBS Waiver Provider Requirements – Standards Assessment and Documentation Review Form (used for site-visits) can be found on the company website at [http://bluecare.bcbst.com/forms/Provider%20Forms/Statewide-HCBS-Waiver-Provider-Requirements.pdf](http://bluecare.bcbst.com/forms/Provider%20Forms/Statewide-HCBS-Waiver-Provider-Requirements.pdf).
When billing for services rendered to CHOICES Members, Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS1500 professional and CMS 1450 facility health insurance claim forms and/or the appropriate electronic filing format. In addition to the following CHOICES-specific billing guidelines outlined below, all BlueCare/TennCareSelect billing guidelines apply (see Section V. Billing and Reimbursement, of this Manual).

The reimbursement rates and codes for CHOICES are based on methodology established by the Division of TennCare and will be updated according to the direction and at the discretion of the Division of TennCare. Only those HCPCS (CPT® and HCPCS Level II) codes on the fee schedule will be considered for reimbursement when filed in conjunction with the corresponding Revenue Code(s) and modifiers listed in the table below, otherwise charges will be denied for billing guidelines. **Services billed outside of the agreement are subject to recovery.** All services require prior authorization.

Providers must comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments, the requirement to report Provider-initiated refunds of overpayments to BlueCare Tennessee and TennCare Office of Program Integrity (OPI) and, when it is applicable, return overpayments to BlueCare Tennessee within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

**Note: Provider Preventable Conditions**
No payment shall be made by BlueCare Tennessee CHOICES to a Provider for Provider-preventable conditions as defined in 42 CFR § 434.6(a)(12) and §447.26. BlueCare Tennessee CHOICES requires Providers to identify Provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

**CHOICES-group specific billing and reimbursement guidelines**

The (3) levels of care categories for the LTSS Program – Choices are as follows:

**Group 1 - Nursing Facility**
- Institutional Level 1 - Custodial Care
- Institutional Level 2 – Enhanced Respiratory Care (ERC)

**Group 2 – HCBS**
- Private Residence
- Community Based Residential Alternatives

**Group 3 - At Risk for Nursing Facility Care**
- Private Residence
- Community Based Residential Alternatives
### Nursing Facility - Institutional Levels 1 and 2

#### NF Revenue Codes Used for NF Room and Board Claims

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0191</td>
<td>Subacute Care - Level 1</td>
<td>Level 1 ICF - Applicable for Short and Long Term Stays</td>
</tr>
<tr>
<td>0224</td>
<td>Date of Discharge – Deceased after 12:00 noon</td>
<td>Level 1 ICF and Level 2 – Applicable for Short and Long Term Stays</td>
</tr>
<tr>
<td>0192*</td>
<td>Subacute Care – Level 2 Enhanced</td>
<td>Chronic Ventilator Care – Billed with CPT® Code 94004</td>
</tr>
<tr>
<td>0192*</td>
<td>Subacute Care – Level 2 Enhanced</td>
<td>Vent Weaning – Billed with CPT® Code 94004 and Modifier SC.</td>
</tr>
<tr>
<td>0192*</td>
<td>Subacute Care – Level 2 Enhanced</td>
<td>Tracheal Suctioning – Billed with CPT® Code 31899</td>
</tr>
<tr>
<td>0224*</td>
<td>Date of Discharge – Enhanced if Deceased after 12:00 noon</td>
<td>Chronic Ventilator Care – Billed with CPT® Code 94004</td>
</tr>
<tr>
<td>0224*</td>
<td>Date of Discharge – Enhanced if Deceased after 12:00 noon</td>
<td>Vent Weaning – Billed with CPT® Code 94004 and Modifier SC.</td>
</tr>
<tr>
<td>0224*</td>
<td>Date of Discharge – Enhanced if Deceased after 12:00 Noon</td>
<td>Tracheal Suctioning – Billed with CPT® Code 31899</td>
</tr>
<tr>
<td>0224*</td>
<td>Date of Discharge – Enhanced if Deceased after 12:00 Noon</td>
<td>Tracheal Suctioning Secretion Management - Billed with CPT® Code 31899 and Modifier SC.</td>
</tr>
</tbody>
</table>

*These services can only be filed electronically (Web or EDI) per HIPAA regulations. Effective with date of service 7/1/2018, LOA is no longer eligible for reimbursement.

**Note:** RC 0224 is utilized to allow a NF to bill for date of death if a resident passes away after 12:00 noon. Medicaid does not pay for Date of Discharge in a NF except in this circumstance. RC 0224 must be billed as the single day/date of death, using patient status code 20 and time of discharge (in military hours) 12:00 p.m. or later, (e.g., patient expires on January 16 at 2 p.m. Revenue code 0191 or 0192 is used for January 1 through January 15 and Revenue code 0224 is used for January 16, patient status code 20 and discharge hour 14:00.)

**Guidelines for Revenue Codes (RC) and Type of Bills (TOB):**

- RC 0191 is restricted to TOB 066x
- RC 0192 is restricted to TOB 021x and must be billed with the appropriate ERC HCPCS Code/Modifier
- RC 0224 can be filed with either TOB 021x or 066x
- All other RCs are restricted to TOB 089x

- For all ICF (Level 1), SNF (Level 2), claims the Occurrence Code 54 with appropriate dates must be billed for Physician Follow-up Date (Last date of a Physician follow-up visit to the patient). If this occurrence code is not filed appropriately, the charges will be denied “WK6” – “Invalid Occurrence Code”.
- All ICF (Level 1), SNF (Level 2) claims filed with a Patient Status of 20, 40, 41, or 42, Occurrence Code 55 and the corresponding date of death must be filed. This is in addition to Occurrence Code 54 listed above. If this occurrence code is not filed appropriately, the charges will be denied “WK6” – “Invalid Occurrence Code”.
- All ICF (Level 1) and SNF (Level 2) Nursing Facility claims must be filed with the appropriate Provider taxonomy code for the level of service billed.
- Services must be billed with the appropriate Revenue Code, CPT®, Modifier, and Type of Bill to be eligible for reimbursement.
The following tables display Revenue Code(s) (RC), HCPCS code(s), and billing units for the HCBS Program – CHOICES. The appropriate HCPCS code should be billed in conjunction with the corresponding RC and modifier(s) according to the following benefit chart:

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Service Description</th>
<th>Available for Consumer Direction</th>
<th>HCPCS Code</th>
<th>Revenue Code</th>
<th>Modifier</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Care Home - Level 2 Day Vent Dependent</td>
<td>A state-licensed community-based residential alternative which offers 24-hour residential care and support in a single family residence to no more than five (5) elderly or disabled adults who meet nursing facility level of care, but who would prefer to receive care in the community in a smaller, home-like setting. The Provider must either live on-site in the home, or hire a resident manager who lives on-site so that the person primarily responsible for delivering care on a day-to-basis is living in the home with the individuals for whom they are providing care.</td>
<td>No</td>
<td>T2033</td>
<td>3109</td>
<td>U1</td>
<td>Day</td>
</tr>
<tr>
<td>Adult Care Home - Level 2 Day Traumatic Brain Injury</td>
<td>Level 2 Per diem</td>
<td>No</td>
<td>T2033</td>
<td>3109</td>
<td>U2</td>
<td>Day</td>
</tr>
<tr>
<td>Adult Care Home - Level 1 Per Month</td>
<td>Level 1 Per Month</td>
<td>No</td>
<td>T2032</td>
<td>3109</td>
<td>U1</td>
<td></td>
</tr>
<tr>
<td>Adult Care Home - Level 2 Month</td>
<td>Level 2 Per Month</td>
<td>No</td>
<td>T2032</td>
<td>3109</td>
<td>U2</td>
<td></td>
</tr>
<tr>
<td>Adult day care</td>
<td>Community-based group programs of care lasting more than three (3) hours per day but less than twenty-four (24) hours per day provided pursuant to an individualized PCSP by a licensed Provider not related to the participating adult.</td>
<td>No</td>
<td>S5100</td>
<td>0570</td>
<td></td>
<td>15 minutes</td>
</tr>
<tr>
<td>Service</td>
<td>HCPCS Service Description</td>
<td>Available for Consumer Direction</td>
<td>HCPCS Code</td>
<td>Revenue Code</td>
<td>Modifier</td>
<td>Unit</td>
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</tr>
<tr>
<td>Assisted Care Living Facility - Day</td>
<td>Personal care services, and medication oversight (to the extent permitted under State law) provided in a home-like environment in a licensed Assisted Care Living Facility. Coverage shall not include the costs of room and board.</td>
<td>No</td>
<td>T2031</td>
<td>3109</td>
<td></td>
<td>Day</td>
</tr>
<tr>
<td>Assisted Care Living Facility - Month</td>
<td></td>
<td>No</td>
<td>T2030</td>
<td>3109</td>
<td></td>
<td>Month</td>
</tr>
<tr>
<td>Assistive technology</td>
<td>Assistive device, adaptive aids, controls or appliances which enable an enrollee to increase the ability to perform activities of daily living or to perceive or control their environment.</td>
<td>No</td>
<td>T2029</td>
<td>0590</td>
<td>U4</td>
<td>Unit equals 1 device</td>
</tr>
<tr>
<td>Attendant care</td>
<td>Hands-on assistance, safety monitoring and supervision of an enrollee who, due to age and/or physical disability, needs more extensive assistance than can be provided through intermittent personal care visits. This may include assistance with activities of daily living such as bathing, dressing and personal hygiene, eating, toileting, transfers and ambulation; assistance with instrumental activities of daily living such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home, or continuous monitoring and supervision because there is no household Member, relative, caregiver, or volunteer to meet the specified need. Attendant care does not include: 1) Care or assistance including meal preparation or household tasks for other residents of the same household;</td>
<td>Yes</td>
<td>S5125</td>
<td>0570</td>
<td></td>
<td>15 minutes</td>
</tr>
<tr>
<td>Service</td>
<td>HCPCS Service Description</td>
<td>Available for Consumer Direction</td>
<td>HCPCS Code</td>
<td>Revenue Code</td>
<td>Modifier</td>
<td>Unit</td>
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</tr>
<tr>
<td>2) Yard work; or</td>
<td>Care of non-service related pets and animals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Companion Care – Back-Up</td>
<td>A consumer-directed residential model in which a CHOICES Member may choose to select, employ, supervise and pay, utilizing the services of a fiscal intermediary, on a daily, weekly, or monthly basis, as applicable, a live-in companion who will be present in the Member’s home and provide frequent intermittent assistance or continuous supervision and monitoring throughout the entire period of service duration. Such model will be available only for a CHOICES Member who requires and does not have available through family or other caregiving supports frequent intermittent assistance with activities of daily living or supervision and monitoring for extended periods of time that cannot be met more cost-effectively with other non-residential services. A CHOICES Member who requires assistance in order to direct his or her companion care may designate a representative to assume consumer direction of companion care services on his/her behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.</td>
<td>Available ONLY in Consumer Direction</td>
<td>S5136</td>
<td>0570</td>
<td></td>
<td>1 Unit</td>
</tr>
<tr>
<td>Companion Care – Daily</td>
<td>5 Days Per Week/24 Hours Per Day</td>
<td>Available ONLY in Consumer Direction</td>
<td>S5136</td>
<td>0570</td>
<td>U1</td>
<td>1 Unit</td>
</tr>
</tbody>
</table>

XXII-39
<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Service Description</th>
<th>Available for Consumer Direction</th>
<th>HCPCS Code</th>
<th>Revenue Code</th>
<th>Modifier</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Companion Care – Daily</td>
<td>7 Days Per Week/24 Hours Per Day</td>
<td>Available ONLY in Consumer Direction</td>
<td>S5136</td>
<td>0570</td>
<td>U2</td>
<td>1 Unit</td>
</tr>
<tr>
<td>Home-delivered meals - Frozen</td>
<td>Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research council) and that will be served in the enrollee’s home. Special diets shall be provided in accordance with the individual PCSP when ordered by the enrollee’s Physician.</td>
<td>No</td>
<td>S5170</td>
<td>0590</td>
<td>U1</td>
<td>Meal</td>
</tr>
<tr>
<td>Home-delivered meals - Fresh</td>
<td>Nutritionally well-balanced meals, other than those provided under Title III C-2 of the Older Americans Act, that provide at least one-third but no more than two-thirds of the current daily Recommended Dietary Allowance (as estimated by the Food and Nutrition Board of Sciences – National Research council) and that will be served in the enrollee’s home. Special diets shall be provided in accordance with the individual PCSP when ordered by the enrollee’s Physician.</td>
<td>No</td>
<td>S5170</td>
<td>0590</td>
<td>U1</td>
<td>Meal</td>
</tr>
<tr>
<td>In-home respite care</td>
<td>Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.</td>
<td>Yes</td>
<td>S5150</td>
<td>0660</td>
<td></td>
<td>15 minutes</td>
</tr>
<tr>
<td>In-patient respite care</td>
<td>Services provided to individuals unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.</td>
<td>No</td>
<td>S5151</td>
<td>0660</td>
<td></td>
<td>Day</td>
</tr>
<tr>
<td>Service</td>
<td>HCPCS Service Description</td>
<td>Available for Consumer Direction</td>
<td>HCPCS Code</td>
<td>Revenue Code</td>
<td>Modifier</td>
<td>Unit</td>
</tr>
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<td>-------------------------------</td>
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<td>--------------</td>
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<td>------------</td>
</tr>
<tr>
<td>Minor home modifications</td>
<td>Provision and installation of certain home mobility aids (e.g., a wheelchair ramp, and modifications directly related to and specifically required for the construction or installation of the ramp, hand rails for interior or exterior stairs or steps, grab bars and other devices) and minor physical adaptations to the interior of a Member’s place of residence which are necessary to ensure the health, welfare and safety of the individual, or which increase the Member’s mobility and accessibility within the residence, such as widening of doorways or modification of bathroom facilities. Excluded are installation of stairway lifts or elevators and those adaptations which are considered to be general maintenance of the residence or which are considered improvements to the residence or which are of general utility and not of direct medical or remedial benefit to the individual, such as installation, repair, replacement of roof, ceiling, walls, or carpet or other flooring; installation, repair, or replacement of heating or cooling units or systems; installation or purchase of air or water purifiers or humidifiers; and installation or repair of driveways, sidewalks, fences, decks, and patios. Adaptations that add to the total square footage are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.</td>
<td>No</td>
<td>S5165</td>
<td>0590</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Personal care visits</td>
<td>Intermittent visits of limited duration to provide hands-on assistance to an enrollee who, due to age and/or physical disability, needs help with activities of daily living such as bathing, dressing and personal care.</td>
<td>Yes</td>
<td>T1019</td>
<td>0570</td>
<td></td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

XXII-41
<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Service Description</th>
<th>Available for Consumer Direction</th>
<th>HCPCS Code</th>
<th>Revenue Code</th>
<th>Modifier</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>hygiene, eating, toileting, transfers and ambulation; assistance with instrumental activities of daily living such as picking up medications or shopping for groceries, and meal preparation or household tasks such as making the bed, washing soiled linens or bedclothes, that are essential, although secondary, to the personal care tasks needed by the enrollee in order to continue living at home because there is no household Member, relative, caregiver, or volunteer to meet the specified need. Personal care does not include: 1) Companion or sitter services, including safety monitoring and supervision; 2) Care or assistance including meal preparation or household tasks for other residents of the same household; 3) Yard work; or 4) Care of non-service related pets and animals.</td>
<td>No</td>
<td>S5160</td>
<td>0590</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Personal Emergency Response System - Installation

Installation costs associated with an electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated. PERS services are limited to those individuals who have demonstrated mental and physical capacity to utilize such system effectively and who live alone or who are alone with no caregiver for extended periods of time such that the individuals safety would be compromised without access to a PERS.
## Service | HCPCS Service Description | Available for Consumer Direction | HCPCS Code | Revenue Code | Modifier | Unit |
--- | --- | --- | --- | --- | --- | --- |
Personal Emergency Response System - Monthly Fee | An electronic device which enables certain individuals at high risk of institutionalization to summon help in an emergency. | No | S5161 | 0590 | | Month |
Pest control | The use of sprays, poisons and traps, as appropriate, in the enrollee's residence (excluding NF, ACLF) to regulate or eliminate the intrusion of roaches, wasps, mice, rats and other species of pests into the household environment thereby removing an environmental issue that could be detrimental to a frail elderly or disabled enrollee's health and physical well-being. | No | S5121 | 0590 | U1 | Visit |
Short Term Nursing Facility Stay | See Nursing Facility – Institutional Levels 1 and 2 Chart within this section | No | | | | |

Providers (excluding Nursing Homes) should use the following bill types for HCBS when billing on an ANSI-837I claim form:

- 891 – Admit
- 892 – Initial or first time billing
- 893 – Intermediate ongoing/continuing
- 894 – Intermediate final billing (discharge or death)

Refer to the [Claims Reference Guide](http://bluecare.bcbst.com/Forms/CHOICES/CHOICES_Claims_Reference_Guide.docx).

Refer to General Billing information (Section V. Billing and Reimbursement) of this Manual for Home Health Agency and Private Duty Nursing billing guidelines.

Refer to Utilization Management Guidelines (Section VIII. Utilization Management Program) of this Manual for Member benefits limitations and authorization guidelines.

**Electronic Billing Instruction**

Facilities wishing to submit claims electronically can contact the BCBST eBusiness Solutions Department at:

- Phone: 423-535-5717
- Fax: 423-535-7523
- e-mail: ecomm_support@bcbst.com
IX. Member Grievances and Appeals

Grievances

When Members and their caregivers have problems or grievances about care or a service Provider, they should report this to the Care Coordinator at 1-888-747-8955. If the Care Coordinator cannot resolve the problem, or if the grievance is about the Care Coordinator, grievances should be escalated to the BlueCare Tennessee Care Coordinator’s Supervisor or the CHOICES Consumer Advocate. If BlueCare Tennessee is unable to resolve the problem or grievance, they may be escalated to the TennCare Solutions Unit, 1-800-878-3192.

Upon receiving a formal Member grievance, BlueCare Tennessee must respond to the complainant in writing within five (5) business days of receipt of the grievance. If the grievance can be resolved within the 5-day time period, the letter will include the resolution and basis for the resolution. If the grievance cannot be resolved, we will send a written notice to the grievant acknowledging receipt of the grievance.

The unresolved grievance will be reviewed, and a written follow-up response will be given to the grievant within thirty (30) calendar days. If the grievance involves abuse, neglect, or mistreatment, BlueCare Tennessee must notify the Division of TennCare at 1-877-224-0219 and, if appropriate, Department of Human Services/Adult Protective Services at 1-888-277-8366 in accordance with T.C.A. 71-6-103(b). Member grievances are documented in the CHOICES System of Record.

Appeals

An explanation of appeal rights is given to a Member upon enrollment in the CHOICES program. When a service is denied, terminated, suspended, reduced, or delayed, the Member must be notified in writing by BlueCare Tennessee stating the reasons for the adverse action taken and include instructions how a Member can file an appeal and have a fair hearing. Providers of CHOICES Members should also assist Members in the appeal process.

Members must be advised that if they file an appeal, they have the right to:
- have an attorney or someone else of their choice to speak for them;
- review information about why the service was denied, reduced, suspended, terminated, or delayed;
- present their evidence;
- ask questions of witnesses who are testifying during a hearing;
- ask for another medical opinion;
- have their services continued if they file an appeal within twenty (20) calendar days; and
- receive a written decision about the outcome of the appeal.

To appeal, a Member must respond within thirty (30) calendar days of the date he/she receives a letter informing him/her that a service has been denied, terminated, suspended, reduced, or delayed. An appeal form can be obtained from the TennCare Solutions Unit. If desired, an appeal can be submitted in any format. See Section VII. Member Policy of this Manual for detailed Member appeal instructions. Members can submit an appeal by mail, fax or phone.

Mail to:  TennCare Solutions Unit  
P O Box 00593  
Nashville, TN 37202-0593

Fax to:  1-888-345-5575  
Call:  1-800-878-3192

Members may request help with their appeal if they have a health, learning, or language problem by asking for the assistance of the BlueCare Tennessee CHOICES Consumer Advocate, or by calling:
- Tennessee Commission on Aging and Disability  1-877-236-0013
- TennCare Solutions Unit  1-800-878-3192

Members having a hearing or speech problem and have a TTY/TDD machine, can call 1-800-772-7647 (TTY/TDD ONLY).

Rev 12/17
X. Provider Appeal Process

See Section XII. Highlights of Provider/Subcontractor Agreement in this Manual for information on Provider payment disputes and independent reviews.
XI. General Information

A. Background Checks and Registry Checks

Background checks must be conducted and evaluated by the Provider on its employees, subcontractors, and agents, prior to providing services, in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS). The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Additionally, all direct support employees hired after 1/1/17 must have all required background checks completed prior to serving any CHOICES Member. Proof of these background checks must be identified during initial and recredentialing site visits and documented in all new hire files. Providers that are non-compliant will be subject to corrective action and/or disqualification from the contracting process.

Employees and volunteers who will not have direct contact with persons, but will have incidental contact only, must have registry checks for all registries listed above, but do not require criminal background checks. Appearance on any registry disqualifies an individual from having incidental contact with a person. Such registry checks must be performed prior to any employee or volunteer having any incidental contact with the person.

For all volunteers and employees who qualify to provide services constituting only incidental contact with persons, the CHOICES Provider shall maintain proof that required registry checks were completed for MCO review during credentialing and re-credentialing visits, as requested.

If a potential employee or volunteer's criminal background check returns results, the Provider must use its discretion as to whether that individual is appropriate to have direct contact with persons. If a potential employee's criminal background check returns results, the Provider must provide the potential employee with an individualized assessment. This individualized assessment must take into account the following three (3) factors:

1. Whether or not the evidence gathered during the individualized assessment shows that the criminal conduct is related to the job in such a way that could place the Member at-risk;
2. The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or the manufacture, sale or distribution of drugs; and
3. The time that has passed since the offense or conduct and/or completion of the sentence.

Providers must clearly identify within their policies, procedures, training and evidence in the employee files the following:

Direct Contact (Hands On)
- The employee/volunteer must have a criminal background check, including the verification of all registries and ongoing monitoring.
- Policies must have language that all checks and registries are conducted prior to any services being rendered.
- Policies must have individualized assessment processes identified.
- Policies shall state that all volunteers and employees, who qualify to support members will have the proof of background and registries maintained for MCO review during credentialing and recredentialing.
- The rosters and employee files will be indicative of the dates and elements outlined, including employees that are no longer employed.
Indirect Contact (Incidental Support)

- Employees that have limited face to face contact with CHOICES or ECF CHOICES Member such as Pest Control, or Home Delivered Meals must have registry checks completed before supporting the Member (Tennessee Abuse Registry, National and Tennessee Sex Offender Registry or LEIE).
- Criminal Background checks are not required.
- Appearance on registries disqualifies incidental contact with a Member.
- Registry check date must be maintained on rosters for MCO auditing during credentialing and recredentialing site visits.

B. Critical Incident Reporting

Critical incidents must be reported if they occur during the provision of covered CHOICES HCBS or are discovered or witnessed by BlueCare, the Provider or Fiscal Employment Agent (FEA) staff regardless of whether the Provider is believed to be responsible for the incident and/or HCBS system factors are believed to have contributed to the incident.

Settings include home and community based long-term care services and support service delivery setting, to include:

- Community-based residential alternatives;
- Adult day care centers; and
- Other CHOICES HCBS Provider sites; and a Member’s home or any other community-based setting.

Critical incidents are defined as:

- Any unexpected death of a CHOICES Member;
- Suspected physical or mental abuse of a CHOICES Member;
- Theft against a CHOICES Member;
- Financial exploitation of a CHOICES Member;
- Severe injury sustained by a CHOICES Member;
- Medication error involving a CHOICES Member;
- Sexual abuse and/or suspected sexual abuse of a CHOICES Member;
- Abuse and neglect and/or suspected abuse and neglect of a CHOICES Member; and

Providers must report Critical Incidents and actions to BlueCare Tennessee CHOICES:

- Within 24 hours* of the Provider’s discovery/awareness of the critical incident.
- The initial report, which may be submitted verbally must include at a minimum the following immediate actions:
  - Status of emergency medical care or law enforcement services; and
  - In critical incidents involving physical and sexual abuse, the Provider must place the worker on administrative leave or in another position in which the worker has no direct contact with or supervisory responsibility of the CHOICES member until the investigation is completed.
  - For all other critical incident types, the Provider has the discretion, per agency policies, to remove the CHOICES worker or not.
  - All reported incidents to APS must be reported to BlueCare CHOICES as a critical incident.

If the initial report is submitted verbally, a written Critical Incident Report form must be submitted to BlueCare Tennessee CHOICES within 48 hours*.

Reports may be submitted verbally by calling 1-888-747-8955, by secure e-mail to CHOICESQuality@bcbst.com (preferred), or by fax at 615-565-1923 twenty-four hours/day, 365 days/year.

Rev 09/18
If the Critical Incident involves Abuse, Neglect, or Exploitation it must also be reported to Adult Protective Services or Child Protective Services within 24 hours of discovery:

<table>
<thead>
<tr>
<th>Adult Protective Services</th>
<th>Child Protective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 1-888-277-8366</td>
<td>Phone 1-877-237-0004</td>
</tr>
<tr>
<td>Fax 1-866-294-3961</td>
<td>Fax 1-866-294-3961</td>
</tr>
</tbody>
</table>

* Note: 24- and 48-hour timeframes equal actual clock hours - NOT business day(s).

HCBS Providers with a critical incident must conduct an internal critical incident investigation as soon as possible and submit the findings of the investigation and their conclusion to BlueCare Tennessee CHOICES no more than twenty (20) days after the first discovery date of the incident.

**Note:** The revised timeframe of twenty (20) days for the follow-up report allows time for BlueCare Tennessee to review the Provider’s actions. If additional actions are needed they must be completed within thirty (30) days of first discovery (regardless if BlueCare Tennessee or the Provider).

Issues related to non-compliance may be escalated to the BlueCare Tennessee HCBS Provider Credentialing Committee for evaluation of the Provider’s continued credentialing eligibility.

Providers are required to cooperate with any investigation conducted by BlueCare Tennessee or outside agencies (e.g., TennCare, Adult Protective Services, and law enforcement).

Providers may access the current version of the BlueCare CHOICES Incident Report form on the company website at [http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html](http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html). Providers may also obtain a copy of the form by calling 1-888-747-8955, or e-mailing CHOICESQuality@bcbst.com.

### C. Neglect and Abuse Information

While providing services, Providers are required to assess a Member for neglect and/or abuse or the potential for abuse and/or neglect. Whenever possible, steps should be taken to reduce a Member’s risk of abuse and/or neglect by collaborating with the Care Coordinator to address potential risks (e.g., frequency of Care Coordinator home visits, referrals to non-covered support services).

Indicators of suspected abuse and/or neglect are:

**General**

Signs and symptoms of abuse and neglect may include physical indicators such as injuries or bruises. There may also be behavioral clues, including how victims and abusers act or interact with one another. Many of the indicators listed below can be explained by other causes (e.g., a bruise may be the result of an accidental fall) and no single indicator can be taken as conclusive proof. However, their presence will be grounds for considering whether a case of suspected abuse or neglect should be reported to the appropriate state agency.

Care Coordinators, subcontractors, Providers and other staff having contact with members will be educated as part of their training to look for patterns or clusters of indicators that suggest problems warranting closer investigation.

Specific signs and symptoms are provided below, by type of abuse and neglect.

**Physical Abuse**

- Sprains, dislocations, fractures or broken bones;
- Burns from cigarettes, appliances or hot water;
- Abrasions on arms, legs or torso that resemble rope or strap marks;
- Cuts, lacerations or puncture wounds;
- Fractures of long bones and ribs;
Internal injuries evidenced by pain, difficulty with normal functioning of organs, and bleeding from body orifices;

- Bruises, welts or discolorations of the following types:
  - Bilateral, or "matching" bruises on both arms that may indicate the member has been shaken, grabbed or restrained
  - Bilateral bruising of the inner thighs that may indicate sexual abuse
  - "Wrap around" bruises encircling the member's arms, legs or torso that may indicate the individual has been physically restrained
  - Clustered bruising on the trunk or another area of the body
  - Bruising in the shape of an object that may have been used to inflict injury
  - Multicolored bruises that may indicate the person has sustained multiple traumas over time, i.e., presence of old and new bruises at the same time;

- Injuries healing through "secondary intention" (indicating that the Member did not receive appropriate treatment), including but not limited to:
  - Lack of bandages on injuries or stitched when indicated
  - Evidence of unset bones;

- Signs of traumatic hair loss, possibly with hemorrhaging below scalp;

- Signs of traumatic tooth loss;

- Injuries that are incompatible with the Member’s explanation;

- Inconsistent or conflicting information from family members about how injuries were sustained;

- A history of similar injuries and/or numerous or suspicious hospitalizations;

- A history of Member being brought to different medical facilities for treatment to prevent medical Practitioners from observing patterns;

- Delays between the onset of injury and seeking of medical care; and

- Signs of confinement (e.g., Member is locked in his or her room).

Sexual Abuse

- Vaginal or anal pain, irritation or bleeding;

- Bruises on external genitalia, inner thighs, abdomen or pelvis;

- Difficulty walking or sitting not explained by other physical conditions;

- Stained or bloody underclothing;

- Sexually transmitted diseases;

- Urinary tract infections, particularly where patterns are observed;

- Inappropriate sex-role relationships between victims and suspects;

- Inappropriate, unusual or aggressive sexual behavior, particularly when it has been recently acquired; and

- Signs of psychological trauma including excessive sleep, depression or fearfulness.

Financial Exploitation

- Visitors ask the Member to sign documents the Member does not understand;

- Unpaid bills, despite adequate financial resources, when a caregiver or other party is expected to be paying the bills;

- Lack of affordable amenities for the Member, such as personal grooming items or appropriate clothing;

- New "best friends" who take an interest in the Member’s finances;

- Legal documents, such as powers of attorney, which the Member did not understand at the time he/she signed them;

- Unusual activity in the Member's bank accounts including large, unexplained withdrawals, frequent transfers between accounts or other activity that the Member cannot explain;

- A caregiver expresses excessive interest in the amount of money being spent on the Member;

- Belongings or property are missing;

- Suspicious signatures on checks or other documents, including signatures not matching the Member’s or signatures and other writing by a Member who cannot write;

- Absence of documentation about financial arrangements;

- Implausible explanations about the Member’s finances are given by the Member or the caregiver; and

- The Member is unaware of or does not understand financial arrangements that have been made for him or her.

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Emotional (Psychological) Abuse

- Berating, ignoring, ridiculing or cursing of a Member;
- Threats of punishment or deprivation;
- Significant weight loss or gain that cannot be attributed to other causes;
- Stress-related conditions including elevated blood pressure;
- The perpetrator isolates the Member emotionally by not speaking to, touching or comforting him/her;
- The Member is depressed, isolated, withdrawn, emotionally upset or non-responsive; and
- The Member cowers in the presence of the suspected abuser or exhibits unusual behavior typically associated with dementia (e.g., sucking, biting, rocking) in the absence of a dementia diagnosis.

Neglect

- Weight loss that cannot be explained by other causes;
- Lack of toileting that causes incontinence, which results in Member sitting in urine and feces;
- Increased falls and agitation, indignity and skin breakdown;
- Pressure ulcers. Although certain types of pressure ulcers are common and difficult to avoid (e.g., where bony protuberances support body weight in Members who have peripheral vascular disease, diabetes, stroke and dementia), other ulcers cannot be readily excused. For example, ulcers on heels, ankles and knees suggest a member has been left for long periods with inadequate padding or repositioning;
- Evidence of inadequate or inappropriate use of medication;
- Personal hygiene is neglected;
- Lack of assistance with eating, drinking, walking, bathing, and participating in activities; and
- Requests for personal assistance are unheeded.

Family/Caregiver Indicators

- Family member/caregiver does not provide an opportunity for the Member to speak for himself or herself or see others without the presence of the caregiver;
- Attitude of indifference or anger toward the Member;
- Family member/caregiver blames the Member for his or her condition (e.g., accusation that incontinence is a deliberate act); and
- Aggressive behavior toward the Member, including threats, insults or harassment.

Any suspicion of abuse and/or neglect should be reported, including suspected and/or neglect of a child pursuant to TCA 37-1-403, reporting suspected abuse and/or neglect of an adult to Adult Protective Services pursuant to TCA 71-6-103, and reporting suspected abuse and/or neglect to BlueCare Tennessee pursuant to Section 2.15.7.1.4. The Provider should coordinate and cooperate with Adult Protective Services/Child Protective Services investigations and remediations.

Necessary steps should be taken to protect the Member from further abuse (e.g., removing a staff person suspected of committing the abuse and/or neglect, making referrals for Members to support services).

D. Coordination with other Managed Care Organizations (MCOs)

For covered long-term services and supports for CHOICES Members who are transferring from another MCO, the receiving MCO is responsible for continuing to provide covered long-term services and supports, including both CHOICES HCBS authorized and nursing facility services, for a minimum of thirty (30) days without regard to whether such services are being provided by contract or non-contract Providers.
For a minimum of thirty (30) days after the Member’s enrollment and thereafter, the receiving MCO shall not reduce the Member’s services unless a care coordinator has conducted a comprehensive needs assessment and developed a PCSP, and the receiving MCO has authorized and initiated CHOICES HCBS in accordance with the Member’s new PCSP.

E. BlueCare Provider Compliance Plan

Providers contracted with BlueCare must adhere to the EVV compliance program in accordance with established metrics and required standards. BlueCare monitors and audits identified measurable elements to ensure providers maintain requirements of the compliance program. Any enforcement and disciplinary process for violations of the program will be conducted in accordance with the guidelines outlined.

Contracted providers are responsible for all EVV record keeping, including any visit maintenance, prior to submitting a claim associated with the EVV record. Providers must ensure the highest quality of support to all members, through continuous and timely monitoring of services for assigned members with authorized services at all times. Providers are responsible for managing and monitoring their Direct Support Professionals (DSP) to ensure approved services are delivered as expected using mandated EVV systems and tools. Immediate attention and action is required by providers when a provider is considered non-compliant. Failure to achieve and maintain compliance as outlined in the assessment of liquidated damages on violations that occurred during the review period, the imposition of contract actions (including contract termination) and/or the corrective action plan process.

Providers should utilize EVV reports to monitor their performance and ensure they are meeting the compliance requirement relative to visit verification and adherence to the compliance standards. The reports can be accessed through the EVV database. Providers should validate the accuracy of claims prior to submissions, in accordance to the authorization effective for the date of service on the claim. When paper time sheets reflect a difference in service times rendered compared to the applicable authorization on file, the schedule will be rejected. Providers must then make corrections to the schedule, and submit the claim to reflect the corrected schedule.

Newly contracted providers that are preparing staff and operational requirements to become compliant to the EVV Compliance program will be allowed a grace period. The grace period should be used to train staff on the system, and ensure that the EVV Coordinators are aware of all performance visit maintenance tasks. The grace period is typically the first ninety days after receiving the provider EVV database. Any grace periods required must be approved by BlueCare.

Provider EVV Compliance Standards

- Provider agencies must adhere to all requirements included in the compliance plan.
- Providers are expected to import all Member referrals within 24 hours of notification.
- Providers will receive authorizations and copies of the Member’s Person Plan of Care (PCSP) indicative of services and service times. Upon receipt of the PCSP, Providers are expected to complete the attestation process in the EVV database.
- Providers are expected to attach the assigned DSP to the Member schedule within 24 hours of importing the new Member.
- Providers must ensure all DSPs have been successfully trained on the GPS EVV tablet, EVV Telephony, and EVV Bring Your Own Device (BYOD). The DSP training record should be documented, including essential refresher and ongoing training when applicable (including how to review schedules, and logging in and out). Training records must include attestation by the DSP that is indicative of the employee’s competency of EVV compliance and standards, including approved clock-in/out procedures.
- Providers are responsible for validating all DSPs are recording Member visits (check in and check out) during the visit using the GPS tablet device, EVV Telephony, or EVV BYOD at all times. If the GPS tablet is not available, DSPs should use EVV Telephony or EVV BYOD as back-up methods.
Adherence to completing all GPS tablet device assessments upon clocking out at the end of Member visits or services is required.

When a DSP identifies an issue with a GPS tablet device, the DSP must clock in using EVV Telephony or EVV BYOD and report the GPS issue to the Provider immediately to prevent missed/late visits.

When a DSP reports an issue with a GPS tablet device, the Provider or responsible EVV Coordinator must contact BlueCare to report the issue within 24 hours of the visit to ensure interference with the quality of care provided to a Member does not occur.

Paper timesheets to document service delivery are only accepted with prior approval as the GPS Tablet Device, and EVV Telephony and EVV BYOD are the approved methods for clocking in and clocking out.

Timely maintenance must be performed daily to clear exceptions; corrections must be completed within one week of the scheduled visit. Providers must ensure all visit maintenance is completed prior to submitting claims.

Any scheduled visit that is identified as missed/late or changed must have populated an acceptable reason code within one day of the missed/late visit.

When the reason code “Member refused service/Member refused Alternate Staff” is entered as a reason code, supporting comments identifying time, date, and person providing the information must be populated in the EVV data base. If the person providing the information is not the Member, the comment must include the person’s name and relationship to the Member.

Providers must receive prior approval from BlueCare when EVV visits require manual confirmation and need paper time sheets for invoicing.

When time sheets are permissible, the following guidelines must be followed and include the following evidence prior to approval for releasing units. Providers may use their own timesheet template to include all standard agency information; and must contain an attestation statement certifying the accuracy of the data that will be submitted.

- Timesheets should record two signatures; the DSP and Member (or Member’s authorized representative and their relationship to Member).
- The signatures must be original; copied signatures will be rejected.
- The service and service date(s) must be accurately exhibited; timesheets submitted prior to service rendered dates will be rejected.
- Signatures must include the date that each signature was obtained.
- Any signature for which signature requirements are not met will be subject to advanced auditing, authentication, and possible Medicaid fraud referral.
- The reason(s) for paper timesheet submissions versus the approved, required use of the EVV system should be included to facilitate approval process.

Provider EVV Compliance Monitoring

Providers are expected to implement EVV Compliance procedures immediately. BlueCare will begin measuring compliance metrics effective March 1, 2018. For the first quarter 2018, BlueCare will look at the months of February and March only. Thresholds for those two months will be averaged to obtain Provider’s performance score for Q1. Q1 will be considered each Provider’s baseline and will be used to show the Provider where areas of improvement are needed. The expected minimum compliance score for Q1 is 70 percent in each area measured, as detailed below. BlueCare will work with Providers to develop corrective action plans based on Q1 performance to assist the Provider in achieving compliance thresholds and improved performance. Compliance threshold expectations (scores) will increase each quarter throughout 2018, as detailed below.

Performance Metrics measured for Provider compliance:

**EVV Activity**

- Provider EVV activity is the number of visits that were provided on time per the Member’s needs and preferences and are captured in the EVV system per the Member’s schedule. Scores will be calculated as total on-time visits divided by the total visits scheduled.
Example:
100 total visits
5 missed visits (weighs same)
5 late visits (weighs same)
90 on-time visits
90/100 = 90% compliance score

- Provider compliance with EVV activity will be monitored on an ongoing basis. The following minimum compliance scores are expected:
  - Q1 – 70%
  - Q2 – 80%
  - Q3 – 90%
  - Q4 – 90% or higher
- Providers that have not met the minimum performance requirements are subject to corrective actions, Member moratoriums, or possible liquidated damages. Possible liquidated damages will not be applied to Q1.

EVV Confirmed Visits
- Provider EVV confirmed visits are visits for which the Provider did not have to request and submit manual confirmations to BlueCare for approval. Manual confirmations are instances in which the Provider submits paper timesheets requesting approval of time submitted. Any visit that is confirmed without any use of EVV for clocking in or clocking out is considered non-compliant and manually confirmed. BlueCare will measure EVV confirmed visits as compliant.
- Scores will be calculated as total manually confirmed visits divided by the total number of visits.

Example:
100 total visits
5 manually confirmed visits
95 EVV confirmed visits
95/100 = 95% compliance score

- Provider compliance with EVV confirmed visits will be monitored on an ongoing basis. The following minimum compliance scores are expected:
  - Q1 – 70%
  - Q2 – 80%
  - Q3 – 90%
  - Q4 – 90% or higher
- Providers that have not met the minimum performance requirements are subject to corrective actions, Member moratoriums, or possible liquidated damages. Possible liquidated damages will not be applied to Q1.

EVV Database Maintenance
- Providers’ EVV database maintenance is the Provider’s appropriate selection of reason codes for missed/late visits and completion of comments as applicable. Provider EVV data base maintenance will be monitored through results from missed visits without reason codes populated in an appropriate or timely manner.
- Scores will be calculated as total missed visits divided by the total missed visits without reason codes plus total missed visits without required comments, as applicable.

Example:
100 total missed visits
5 missed/late visits w/o reason codes/comments
95 missed visits with reason codes/comments
95/100 = 95% compliance score
Provider EVV Claims Compliance

- All claims must be submitted within 120 days from the date of service or will be subject to denials. It is highly recommended that claims are submitted within seven (7) days of the Member visits in support of properly maintained EVV data bases.
- The billable hours, including start time and end time, for the scheduled service must match the timesheet; in the event there is a mismatch between the submitted timesheet and the EVV record, the request for unit release or approval of manual confirmation will be denied.
- Reoccurrence and ongoing requests for unit releasing or manual confirmation request for claim submissions are cause for heightened review of data base maintenance and probable cause for corrective action.

Overall Provider Compliance

Overall Provider compliance will be calculated by averaging the compliance percentages of each metric above.

- Providers that maintain a minimum 90% compliance score will be considered a preferred Provider.
- Providers with preferred Provider status will be considered first for Member referrals.

Compliance Monitoring Process

BlueCare will utilize EVV reports claims submission data to determine Provider compliance. Monitoring activities will be conducted the first week of each month for the previous month’s performance.

Providers will receive monthly EVV Compliance Reports detailing the Provider’s performance of the previous month. Providers are expected to review each report upon receipt and take appropriate actions to obtain EVV compliance where applicable. Technical assistance and support will be provided by the BlueCare Provider Network Manager. If Provider performance warrants, BlueCare may require the provision of technical assistance and support to develop and implement a corrective action plan. Providers have access to reports that may be generated by their EVV Coordinators and obtained on an ad hoc basis to maintain compliance. Providers are encouraged to utilize these reports to achieve maximum compliance with the EVV Compliance Plan.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Provider Compliance Plan</td>
<td>A set of requirements that establish a standard for EVV usage that must be adhered to by Provider agencies.</td>
</tr>
<tr>
<td>Grace Period</td>
<td>A timeframe during which Provider agencies must use an EVV system and may, for billing support purposes only, use paper timesheets as backup documentation. Provider agencies that are in a grace period are not subject to liquidated damages, contract actions, or corrective action plan requirements for failing to achieve a compliance plan score of at least 90% any of the compliance standards. Grace periods are usually the first three (3) months for newly contracted Provider approved as a participating Provider in the BlueCare network. However, claims may still be subject to denial or recoupment.</td>
</tr>
</tbody>
</table>
Term | Definition
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Provider Compliance Plan Review Period | The standard review period will be each month. Additionally, Providers may receive ad hoc reviews as required by BlueCare when the performance of a Provider deems more frequent reviews and monitoring.
Manual Confirmations | Any EVV Member visit that is confirmed without any EVV usage.
Data Base Maintenance | Activities required to maintain Provider and Member data, including PCSP attestations, exceptions and reason code population, and any other tasks required to have accurate and timely information pertaining to monitoring and billing for LTSS services.

Any questions pertaining to the BlueCare Compliance Program should be directed to the CHOICESProviderRelations@bcbst.com email box.

F. Nursing Facility Patient Liability

Nursing facility providers are required to collect the CHOICES nursing facility Member patient liability amounts. If a Member refuses to pay their patient liability obligation, the Provider must provide adequate notice to the Member and make a diligent effort to resolve and address issues related to untimely or non-payment. This shall include notifying the Member’s BlueCare Tennessee CHOICES Care Coordinator who will intervene and address issues as they arise that may influence the payment of patient liability. The Care Coordinator will counsel the Member regarding the consequences of not paying his/her patient liability to include the potential of loss of CHOICES benefits and in addition the potential loss of eligibility for TennCare if the sole qualification was based on long-term service and support eligibility. A nursing facility may refuse to continue providing services to a Member who fails to pay his or her patient liability and for whom the nursing facility can demonstrate to BlueCare Tennessee that it has made a good faith effort to collect payment.
XXIII. Employment and Community First (ECF) CHOICES Program

(Does Not Apply to CoverKids)

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I. Introduction

The TennCare Employment and Community First (ECF) CHOICES program is a managed care long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program. The primary goal of ECF CHOICES is to promote and support integrated, competitive employment and independent living as the first and preferred option for all individuals with intellectual and developmental disabilities.

ECF CHOICES is designed for people with intellectual and other developmental disabilities who are not currently receiving services. ECF CHOICES offers:

1. Supports for families caring for a person with an intellectual or development disability
2. Supports to help ECF CHOICES enrollees achieve employment and independent living goals.
3. Residential and other day services to help people who cannot work or need more support to live in the community achieve their community goals.
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II. Eligibility/Enrollment

To be eligible for enrollment in the ECF CHOICES program, an individual must have an intellectual or developmental disability.

**Developmental disability** in a person over five (5) years of age means a condition that:
- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Manifested before twenty-two (22) years of age;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three (3) or more of the following major life activities:
  - Self-care;
  - Receptive and expressive language;
  - Learning;
  - Mobility;
  - Self-direction;
  - Capacity for independent living; or
  - Economic self-sufficiency; and
- Reflects the person’s need for a combination and sequence of special interdisciplinary or generic services, supports, or other assistance that is likely to continue indefinitely and need to be individually planned and coordinated.

**Developmental disability** in a person up to five (5) years of age means a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disability as defined for persons over five (5) years of age if services and supports are not provided.

If currently enrolled in BlueCare or TennCareSelect – call the customer service number on the back of the Member ID card.

**Intellectual disability** is defined as substantial limitations in functioning:
- As shown by significantly sub-average intellectual functioning (IQ 70 or below) that exists concurrently with related limitations in two (2) or more of the following adaptive skill areas:
  - Communication;
  - Self-care;
  - Home living;
  - Social skills;
  - Community use;
  - Self-direction;
  - Health and safety;
  - Functional academics;
  - Leisure; and
  - Work; and
- That is manifested before eighteen (18) years of age.

**ECF CHOICES is made up of five (5) Groups, each with distinct eligibility/enrollment requirements and benefits:**

**Group 4 (Essential Family Supports)**
Children under age twenty one (21) with I/DD living at home with family who meet the Nursing Facility Level Of Care and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of
HCBS, are “At risk of NF placement;” and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are “At risk of NF placement,” and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

**Group 5 (Essential Supports for Employment and Independent Living)**
Adults age twenty-one (21) and older with I/DD who do not meet NF LOC, but who, in the absence of HCBS are “At Risk” of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

**Group 6 (Comprehensive Supports for Employment and Community Living)**
Adults age twenty-one (21) and older with I/DD who meet NF LOC and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.

**Group 7 (Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS))** – Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment, children under age twenty one (21) who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration). The child must meet the NF LOC and need and receive HCBS as an alternative to NF Care. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. This group shall be implemented by MCO based on TENNCARE’s determination of the MCO’s readiness to deliver services statewide and in accordance with program requirements.

**Group 8 Intensive Behavioral Community Transition and Stabilization Services (IBCTSS)**
Except as modified in the final approved amendment to the TennCare 1115 Demonstration and only upon approval and implementation of such amendment, adults age twenty-one (21) and older, unless otherwise specified by TENNCARE, with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment, meet nursing facility level of care, and need and are receiving specialized services for I/DD. A person must be in one of the following target groups: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term institutional placement (including residential psychiatric treatment facility). To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group. On a case-by-case basis, TENNCARE may grant an exception to permit adults ages eighteen (18) to twenty (20) with I/DD not living at home with family, including young adults with I/DD transitioning out of State custody, to enroll in Group 8, if they meet eligibility criteria. This group shall be implemented by MCO based on TENNCARE’s determination of the MCO’s readiness to deliver services statewide and in accordance with program requirements.
TennCare enrollees will be enrolled by TENNCARE into ECF CHOICES via the below referral process consisting of three steps: screening, intake, and enrollment.

Screening
Screening provides basic education about the program, including eligibility criteria and enrollment processes, and helps to gather basic information that can be used to determine if the potential applicant is likely to qualify for the program and that allows the potential applicant to be prioritized for intake based on established prioritization and enrollment criteria. The following outlines the ECF CHOICES screening process:

1. Potential applicants for ECF CHOICES complete an online self-screening tool. For current BlueCare Members who need assistance with completion of the self-screening tool, BlueCare staff will assist the Member via telephone with completion of the self-screening.
2. The results of the applicant self-screenings are captured in a referral tracking system.
3. If the potential applicant does not appear to meet the eligibility criteria for enrollment into ECF CHOICES, the person will be advised accordingly and given the opportunity to be placed on the referral list for potential intake and enrollment into the program at a later time.
4. If the potential applicant does appear to meet the eligibility criteria for enrollment into ECF CHOICES, the process proceeds to the intake phase.

Intake
Intake helps to gather basic information that will help to confirm information provided in the screening process and allows a person to be prioritized for enrollment based on established prioritization and enrollment criteria. If a potential applicant meets the online screening criteria, the following intake steps occur:

1. BlueCare schedules a face-to-face intake visit with the Member as follows:
   a. For Members who meet screening criteria and are in one of the priority categories for which enrollment is currently open or who may qualify in a reserve slot and for which slots are currently available, the intake visit is to be completed within five (5) business days of the screening.
   b. For all other Members on the referral list, the intake visit is to be completed within thirty (30) calendar days of completing the screening.
2. During the visit, the BlueCare Support Coordinator collects all required supporting documentation to complete the intake packet and gather information that will allow the Member to be prioritized for enrollment by TennCare.
3. If the documentation obtained is sufficient to reasonably establish that the Member has an ID or DD:
   a. BlueCare may proceed with the enrollment steps if the Member qualifies for an available reserve slot based on an aging caregiver.
   b. BlueCare may proceed with the enrollment steps if the Member qualifies in an available program slot based on prioritization criteria for which enrollment is currently open.
   c. BlueCare may submit a referral to the interagency review committee if the Member could potentially qualify for a reserve slot based on emergent circumstances or multiple complex health conditions.
   d. BlueCare may confirm or modify as applicable the person’s placement on the ECF CHOICES referral list.
4. If the documentation obtained is not sufficient to reasonably establish that the person has an ID or DD, BlueCare will advise the Member that they do not appear to meet target population for enrollment into ECF CHOICES. BlueCare will further advise that the Member may request to remain on the ECF CHOICES referral list.

Enrollment
Enrollment into ECF for existing BlueCare Members occurs when a person has been determined to meet criteria for an available reserve slot or for one of the prioritization categories for which enrollment is
currently open, and when there is an appropriate slot available for the person to enroll. Enrollment includes:

1. Within 5 business days of determination to proceed with enrollment of a Member into ECF CHOICES, the Support Coordinator conducts a second face-to-face visit to complete the enrollment packet. As indicated above, the intake and enrollment visit may be combined in circumstances where it is known at intake that the Member may be enrolled.

2. During the enrollment visit, the Support Coordinator provides to the Member:
   a. ECF CHOICES Education materials
   b. Freedom of ECF CHOICES Counseling

3. The Support Coordinator completes an enrollment packet which includes:
   a. All documentation necessary for a Level of Care Determination (Pre Admission Evaluation)
   b. Any additional evidence, including documented observations, supporting ID and/or DD diagnosis;
   c. Signed acknowledgement by Member that general information about ECF CHOICES and information about estate recovery and patient liability counseling was provided.
   d. All other documents as applicable such as: Freedom of ECF CHOICES Form, Consumer Direction Participation Forms, Initial Person-Centered Support Plan, etc.

4. Within 5 business days of the face-to-face enrollment visit, BlueCare submits all necessary documentation to TennCare.

TennCare reviews the information submitted by BlueCare to confirm the Member is in the target population and determines medical eligibility. The enrollment into ECF CHOICES it not final until the Member information is transmitted from TennCare to BlueCare Tennessee via the electronic 834 enrollment file. Notification via the 834 occurs after TennCare approves financial eligibility and Nursing Facility as applicable.

Upon enrollment, each ECF CHOICES Member receives a plastic Member ID card reflecting his/her Primary Care Provider (PCP) name and effective date. A new ID card is issued each time the Member changes his or her PCP. The single contact number for BlueCare Tennessee ECF CHOICES is located on the back of the ID card.

A sample copy of the BlueCare ECF CHOICES Member ID card follows:

Front

Back
III. Benefits

A. Covered Services

ECF CHOICES Members receive the same benefits as all other BlueCare Members (see Section IV. Benefits, in this Manual). Additionally, the following long-term services and supports are available to ECF CHOICES Members when the services have been identified as needed by the BlueCare Tennessee Support Coordinators or person centered support plan (PCSP), as applicable.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
<th>Group 7</th>
<th>Group 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite (up to 30 days per calendar year or up to 216 hours per calendar year only for persons living with unpaid family caregivers)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Supportive home care (SHC)</td>
<td>X</td>
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<tr>
<td>Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)</td>
<td>X</td>
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</tr>
<tr>
<td>Community integration support services (subject to limitations specified in the approved 1115 waiver and TennCare Rule)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Independent living skills training (subject to limitations specified in the approved 1115 waiver and TennCare Rule)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Assistive technology, adaptive equipment and supplies (up to $5,000 per calendar year)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Community support development, organization and navigation</td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Family caregiver education and training (up to $500 per calendar year)</td>
<td>X</td>
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<tr>
<td>Family-to-family support</td>
<td>X</td>
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<tr>
<td>Conservatorship and alternatives to</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
</tbody>
</table>

XXIII-9
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
<th>Group 7</th>
<th>Group 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>conservatorship counseling and assistance (up to $500 per lifetime)</td>
<td></td>
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<td></td>
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<tr>
<td>Decision-making supports (up to $500 per lifetime)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health insurance counseling/forms assistance (up to 15 hours per calendar year)</td>
<td>X</td>
<td></td>
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<tr>
<td>Personal assistance (up to 215 hours per month)</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Community living supports (CLS)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Community living supports—family model (CLS-FM)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Individual education and training (up to $500 per calendar year)</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/Self-Employment and Independent Community Living (up to $1,500 per lifetime)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Specialized consultation and training (up to $5,000 per calendar year[^1])</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Adult dental services (up to $5,000 per calendar year, up to $7,500 across three consecutive calendar years)</td>
<td>X[^2]</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Employment Services/Supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

[^1] For adults in the Group 6 benefit group determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.

[^2] Limited to adults age 21 and older
### Benefit Group Table

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Group 4</th>
<th>Group 5</th>
<th>Group 6</th>
<th>Group 7</th>
<th>Group 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported employment—individual employment support</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- Exploration</td>
<td></td>
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<tr>
<td>- Benefits counseling</td>
<td></td>
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<tr>
<td>- Discovery</td>
<td></td>
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<td></td>
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<tr>
<td>- Situational observation and assessment</td>
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<tr>
<td>- Job development plan or self-employment plan</td>
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<td></td>
</tr>
<tr>
<td>- Job development or self-employment start up</td>
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<tr>
<td>- Job coaching for individualized, integrated employment or self-employment</td>
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<tr>
<td>- Co-worker supports</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>- Career advancement</td>
<td></td>
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</tr>
</tbody>
</table>

| Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS) |         |         |         | X       |         |
| Intensive Behavioral Community Transition and Stabilization Services (IBCTSS)        |         |         |         |         | X       |
| Behavioral Health Community Stabilization and Transition for no more than 90 days | X       | X       | X       | X       |         |
| Behavioral Health Community Stabilization and Transition for no more than 90 additional days | X       | X       | X       | X       | X       |

**Note:** In addition to the benefits specified above, a person enrolled in ECF CHOICES may receive short-term nursing facility care as Medically Necessary for up to ninety (90) days. A person enrolled in ECF CHOICES receiving short-term nursing facility care will not be required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission.
B. Exclusions

BlueCare Tennessee makes the exclusion list available through this Manual (see Section IV. Benefits).
Note: The Division of TennCare is solely responsible for the addition or deletion of any service or supply.

The Division of TennCare’s benefit exclusions can also be viewed in the Exclusions section of the TennCare Rules located at http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20171224.pdf (TennCare Medicaid) or http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-14.20171224.pdf (TennCare Standard). The services, products and supplies listed in the exclusion rules apply to all Members unless the rules require a Medical Necessity review for Members under the age of 21 years. Providers are encouraged to routinely view the most current Exclusions list available on the Division of TennCare’s website. (See above TennCare Rules Web address.)

C. Consumer Direction

Each ECF CHOICES Member assessed to need specified types of HCBS including personal assistance, supportive home care, respite, and community transportation; and/or any other service specified in TennCare rules and regulations as available for consumer direction is given the opportunity to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s).

A Consumer-Directed Worker is an individual who has been hired by a ECF CHOICES Member participating in consumer direction of eligible ECF CHOICES HCBS or his/her representative to provide one or more eligible ECF CHOICES HCBS to the Member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the Member.

D. Money Follows the Person (MFP)

Money Follows the Person (MFP) is a federal grant established under the Deficit Reduction Act and extended under the Affordable Care Act that will assist Tennessee in transitioning Eligible Individuals from a Qualified Institution into a Qualified Residence in the community and in rebalancing long-term care expenditures. The grant provides enhanced match for HCBS provided during the first 365 days of community living following transition.

Each MFP participant in ECF CHOICES will have a Support Coordinator who works with the individual. Members will receive the ECF CHOICES Services that the Member and Support Coordinator determine are needed. Please contact your Provider Network Manager for detailed program participation information.
IV. Support Coordination

A. Person Centered Support Plan (PCSP)

The Person Centered Support Plan is a written plan developed by the Support Coordinator using a person-centered planning process that documents the Member’s strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the Member to help them achieve their preferred lifestyle and goals, and to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services.

The planning process is directed by the Member with long-term support needs unless he or she has a court-appointed guardian or conservator, and may include a representative whom the Member has freely chosen to assist the Member with decision-making, and others chosen by the Member to contribute to the process. This planning process, and the resulting initial support plan, will assist the Member in achieving a personally defined lifestyle and outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth.

The Person Centered Support Plan will include, but not be limited to:

- Pertinent demographic regarding the Member, including but not limited to, the Member’s current address and phone number(s), the name and contact information of any representative, and a list of other persons authorized by the Member to have access to health care related information;
- Documentation that the setting in which the Member resides is chosen by the Member and meets the HCBS Settings Rule Requirements;
- The Member’s strengths and interests;
- Person-centered goals and objectives, including employment (as applicable) and integrated community living goals, and desired wellness, health, functional, and quality of life outcomes for the Member, and how ECF CHOICES services are intended to help the Member achieve these goals.
- Risk factors for the Member and measures in place to minimize them;
- Support, including specific tasks and functions that will be performed by family members and other caregivers;
- Caregiver training or supports identified through the caregiver assessment that are needed to support and sustain the caregiver’s ability to provide care for the Member;
- Home health and private duty nursing that will be authorized by BlueCare Tennessee, as well as home health, private duty nursing, and long-term care services the Member will receive from other payor sources;
- ECF CHOICES HCBS that will be authorized by BlueCare Tennessee, including:
  - The amount, frequency, duration, and scope (tasks and functions to be performed) of each service to be provided;
  - How such services should be delivered, including the Member preferences; and
  - The schedule at which such care is needed.
- A detailed back-up plan for situations when regularly scheduled ECF HCBS Providers are unavailable or do not arrive as scheduled; the back-up plan may include paid and unpaid supports and will include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts; and
- Description of the Member’s current physical and behavioral health conditions and functional status (i.e., areas of functional deficit), and the Member’s physical, behavioral and functional needs;
- Description of the Member’s physical environment and any modifications necessary to ensure the Member’s health and safety;
- Description of medical equipment used or needed by the Member (if applicable);
- Description of any special communication needs including interpreters or special devices;
The primary language spoken by the Member and/or his or her primary caregiver, or the use of other means of effective communication, such as, sign language and other auxiliary aids or services, as applicable, and a description of any special communication needs including interpreters or special devices;

- A description of the Member’s psychosocial needs, including any housing or financial assistance needs which could impact the Member’s ability to maintain a safe and healthy living environment;

- For Members receiving CBRA services, a description of the Member’s capabilities and desires regarding personal funds management;

- Description of any other services that will be provided to the Member;

- Relevant information regarding the Member’s physical health conditions;

- Frequency of planned support coordinator contacts as needed;

- For Members participating in consumer direction, additional information should be included to identify the specific services that will be consumer directed and if the Member requires a representative to participate in consumer direction;

- Any steps the Member should take in the event of an emergency that differ from standard emergency protocol as well as a disaster preparedness plan specific to the Member; and

- The Member's TennCare eligibility end date.

### B. New Member Support Coordination

The Support Coordinator will contact the ECF CHOICES Member within ten (10) business days of notice of the Member’s enrollment in ECF CHOICES, conduct a face-to-face visit with the Member, initiate a comprehensive needs assessment in a manner sufficient to ensure needs are identified and addressed in the PCSP, as applicable, conduct a caregiver assessment, and authorize and initiate ECF CHOICES HCBS.

The PCSP will identify ECF CHOICES HCBS that are needed by the Member on an interim basis while the comprehensive PCSP is developed. ECF CHOICES HCBS identified in the PCSP shall be authorized for no more than thirty (30) calendar days, pending development of the PCSP which shall identify ongoing ECF CHOICES HCBS needed.

Within thirty (30) calendar days of the enrollment notice, the support coordinator will complete the comprehensive needs assessment, develop the PCSP and authorize and initiate services as specified in the initial PCSP.

### C. Ongoing Support Coordination

**ECF CHOICES Group 4** Members will be contacted by their support coordinator at least quarterly. Such contacts shall be either in person or by telephone. These Members shall be visited in their residence face-to-face by their support coordinator at least semi-annually. Face-to-face and/or telephone contacts shall be conducted more frequently when appropriate based on the Member’s needs and/or request which shall be documented in the PCSP, or based on a significant change in needs or circumstances.

**ECF CHOICES Group 5** Members will be contacted by their support coordinator at least monthly. The contacts will be either in person or by telephone. These Members will be visited in their residence face-to-face by their support coordinator at least quarterly. Face-to-face and/or telephone contacts will be conducted more frequently when appropriate based on the Member’s needs and/or request which will be documented in the PCSP, or based on a significant change in needs or circumstances.

**ECF CHOICES Group 6** Members determined by an objective assessment to have low to moderate need and not to have exceptional medical or behavioral needs will be contacted by their support coordinator at
least monthly either in person or by telephone. These Members will be visited in their residence face-to-face by their support coordinator at least bi-monthly (i.e., every other month). Face-to-face and/or telephone contacts will be conducted more frequently when appropriate based on the Member’s needs and/or request which will be documented in the PCSP, or based on a significant change in needs or circumstances.

ECF CHOICES Group 6 Members determined by an objective assessment to have high need and Members in ECF CHOICES Group 6 determined by an objective assessment to have exceptional medical or behavioral needs (including Members with low to moderate need who have exceptional medical or behavioral needs) will be visited in their residence face-to-face by their support coordinator at least once a month. More frequent face-to-face and/or telephone contacts will be conducted when appropriate based on the Member’s needs and/or request which will be documented in the PCSP, or based on a significant change in needs or circumstances.

The Member’s Support Coordinator/support coordination team will ensure that the Member reviews, signs and dates the PCSP as well as any updates, as necessary. The Support Coordinator will also sign and date the initial SP, along with any updates, as specified by TennCare. The Provider, also, receives copies of the approved PCSP; their acknowledgment by electronic mechanism or through proxy is obtained, indicating their receipt and understanding of all relevant service provisions they will be providing to the Member.

When the refusal to sign is due to a Member’s request for additional services, (including requests for a different type or an increased amount, frequency, scope, and/or duration of services than what is included in the PCSP) BlueCare Tennessee will, in the case of a new PCSP, authorize and initiate services in accordance with the PCSP. In the case of an annual or revised PCSP, BlueCare Tennessee will ensure continuation of at least the level of services in place at the time the annual or revised PCSP was developed until a resolution is reached, which may include resolution of a timely filed appeal. BlueCare Tennessee will not use the Member’s acceptance of services as a waiver of the Member’s right to dispute the PCSP, as applicable or as cause to stop the resolution process.

The Member’s Support Coordinator/support coordination team will provide a copy of the Member’s completed PCSP, including any updates, to the Member, the Member’s representative, and the Member’s community residential alternative Provider, as applicable. The Member’s Support Coordinator/support coordination team will provide copies of the Provider PCSP, as applicable to other Providers authorized to deliver care, and will ensure that Providers are informed in writing of all relevant information needed to ensure the provision of quality care for the Member and to help ensure the Member’s health, safety and welfare, including the tasks and functions to be performed.

Within five (5) business days of completing a reassessment of a Member’s needs, the Member’s Support Coordinator will update the Member’s initial SP as appropriate, authorize and initiate HCBS in the updated PCSP, as applicable.

The Member’s Support Coordinator will inform each Member of his or her eligibility end date and educate Members regarding the importance of maintaining TennCare ECF CHOICES eligibility, that eligibility must be re-determined at least once a year, and that Members receiving ECF CHOICES HCBS will be contacted by TennCare near the date a re-determination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

ECF CHOICES Group 7 – Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS) is targeted to providing intensive in-home, family-centered behavior supports, behavioral-focused supportive home care, caregiver training and support, combined with crisis intervention and stabilization assistance that is available 24 hours a day, 7 days a week, and in-home behavioral respite when needed for a relatively small group of children (under age 21) who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or
psychiatric conditions that place the child or others at significant risk of harm and threaten the sustainability of the family living arrangement. These are children at significant risk of placement outside the home (e.g., state custody, hospitalization, residential treatment, incarceration).

Families who have children with I/DD and severe behavioral health and/or psychiatric conditions may be experiencing significant amounts of physical and emotional distress resulting from the continuous needs and risks associated with their child’s behavior. While the family and the person may desire to continue living together, they may be faced with the need for a higher level of care (e.g., hospitalization, residential treatment) or other placement outside the home (e.g., State custody, incarceration), if they do not get the assistance needed within the home.

High-quality behavioral health services delivered by qualified mental health professionals and tailored to the needs of children with I/DD will be integrated with the IBSHC benefit to support the family in the consistent and effective implementation of the child’s behavior support plan in all aspects of daily life. IBSHC will be delivered by Direct Support Professionals who have targeted training and expertise in supporting people with significant behavioral challenges and access to direct guidance from the mental health professionals who are employed by or contracted with the IBSHC Provider. While the service is intended to provide support for family caregivers, it is not intended to supplant the supports provided by natural caregivers, but rather to build the capacity of families to better provide natural supports by teaching, training and supporting them in their caregiving role.

ECF CHOICES Group 8 – Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) is targeted primarily to providing short-term intensive 24/7 community-based behavioral-focused transition and stabilization services and supports to assist adults aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.

People with I/DD and co-occurring severe behavioral health conditions who have been either living in their family’s home or residing in a setting that provided a high degree of structure, supervision, and/or treatment may experience significant challenges when moving to a more independent life in the community. Sometimes the very structure, supervision, and treatment they were receiving contained the severe behaviors and limited the factors that may create the challenges to be faced in the community. For example, a person who has been incarcerated for months following an aggravated assault has not had the opportunity to be in situations that may have been a factor in that assaultive behavior. Thus, planning for a return to the community with the supports and services in place to ensure the person’s and others’ safety is actually hindered by the inability to adequately assess the person’s needs in a community environment. Likewise, a person transitioning from a long-term residential or inpatient setting may still have significant psychiatric and behavioral needs, though s/he no longer meets criteria for a continued inpatient stay. While in the hospital, the person had limited and supervised social interactions, so how s/he may respond to stressors and freedoms in a community setting is largely an unknown.

IBCTSS offers a short-term (initial authorization period of up to 90 days with limited extensions) behavioral-focused residential planning, stabilization and treatment program that addresses the mental health and stabilization needs of: 1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; 2) emerging young adults (age 18-21) with I/DD and severe psychiatric or behavioral symptoms aging out of the foster care system; and 3) adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term (two or more years) institutional placement (including residential psychiatric treatment facility). The purpose of Comprehensive Behavioral Supports for Employment and Community Living (Group 8) is to help stabilize the individual in the community and to help plan and prepare for transition to the appropriate ECF CHOICES Group (likely to be Group 6 in most cases), once it is possible to conduct
appropriate assessments and determine the level of services and supports that will be needed going forward.

Integrated behavioral health and IBCTSS are provided by a team led by a Master’s level mental health clinician and including Bachelor’s level mental health workers or other appropriately qualified Direct Support Professionals with training and expertise in serving individuals with I/DD who have a severe behavioral and/or psychiatric condition. This team provides comprehensive person-centered planning; coordination with the treating mental health practitioner (i.e., psychiatrist or other licensed prescriber); and intensive therapeutic support and intervention, up to 24 hours a day, as needed, in all of the person’s day-to-day life domains, including home, school, work and community, in order to achieve stability, support the person in building healthy relationships, and successfully plan and transition to other long-term services and supports with appropriate behavioral health treatment services. Providers of IBCTSS must maintain a written agreement with or employ a psychiatrist or other appropriately licensed psychiatric professional to facilitate timely access to psychiatric care, as needed.

**D. Integrated Support Coordination Team**

Integrated Support Coordination Team (IST) – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the Member’s Support Coordinator and the Behavior Supports Director as defined in 2.29.1.3.6 or a similarly qualified behavior supports professional, who shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning.

**E. Authorizations**

BlueCare Tennessee does not require home and community based services to be ordered by a treating Physician, but the Support Coordinator may consult with the treating Physician as appropriate regarding the Member’s physical health, behavioral health, and long-term service and support needs and in order to facilitate communication and coordination regarding the Member’s physical health, behavioral health, and long-term services and supports.

For Members enrolled in ECF CHOICES the Support Coordination team will be responsible for ensuring services are authorized and initiated as outlined in the Member’s initial SP within ten (10) business days of notice of Member’s enrollment with the exception of the following:

ECF CHOICES HCBS identified in the PCSP, as applicable shall be authorized for no more than thirty (30) calendar days, pending development of the PCSP which shall identify ongoing ECF CHOICES HCBS needed. Within thirty (30) calendar days of the enrollment notice, the support coordinator will complete the comprehensive needs assessment, develop the PCSP and authorize and initiate services as specified in the PCSP.

1. Assistive Technology – thirty (30) days
2. Minor Home Modifications – ninety (90) days
3. Respite – In accordance with the Member’s needs as specified in the PCSP

Services must be provided in accordance with the approved PCSP, within the Member’s service schedule, and be authorized, as applicable, in order to receive reimbursement for the services rendered. The service authorization will include the amount, frequency and duration of each service to be provided and the schedule at which such care is needed, as applicable, the requested start date, and other relevant information as needed.
Support Coordinators collaborate with other state and local departments and agencies to verify that coordinated care is provided to Members. This includes, but is not limited to coordination with:

- Tennessee Department of Intellectual and Developmental Disabilities (DIDD) for purposes of the integration and coordination of care;
- Tennessee Department of Health (DOH), for the purposes of establishing and maintaining relationships with Member groups and health service Providers;
- Tennessee Department of Human Services (DHS) and Department of Children’s Services (DCS) Protective Services Section, for the purposes of reporting and cooperating in the investigation of abuse and neglect;
- Tennessee Department of Education (DOE) and local education agencies for the purposes of coordinating educational services in compliance with the requirements of Individuals with Disabilities Education Act (DEA) and to determine that school-based services for students with special needs are provided;
- Tennessee Commission on Aging and Disability (TCAD) and Division of TennCare, Long Term Services and Supports Division for the purposes of coordinating care for Members requiring long-term services and supports;
- Local law enforcement agencies and hospital emergency rooms for the purposes of crisis service Provider relationships, and the transportation of individuals certified for further assessment for emergency psychiatric hospitalization.
V. Provider Roles and Responsibilities

A. Primary Care Provider

Primary Care Providers (PCPs) are responsible for the overall health care of ECF CHOICES Members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all Medically Necessary and Covered Services;
- Initiating and/or authorizing referrals for specialty care;
- Monitoring the continuity of Member care services;
- Routine office visits for new and established Members;
- ECF CHOICES Members services;
- Collaboration with the care coordinator;
- Hearing services including: screening test, pure tone audiometry, air only audiometry, pure tone audiometry and air only audiometry hearing services;
- Counseling and risk intervention, family planning;
- Immunizations;
- Administering and interpreting of health risk assessment instrument;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide Covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

B. Support Coordinator

The Support Coordinator is the individual who has primary responsibility for performance of support coordination activities for ECF CHOICES Members. For ECF CHOICES Members, the Member’s Support Coordinator shall ensure continuity and coordination of physical health, behavioral health, and long-term services and supports, and facilitate communication and ensure collaboration among physical health, behavioral health, and long-term service and support Providers.

The Support Coordinator will:

1. Conduct person-centered needs assessment to develop the Person Centered Support Plan (PCSP) for Groups 4, 5 and 6 based on the Member’s needs;
2. Provide information to the Member about preferred Providers and service Providers to enable Members to make an informed decision about their choice and selection of Providers; will also assist the Member in identifying Providers that are linguistically competent in the Member’s primary spoken language or sign language, or other forms of communication including assistive devices;
3. Support the ECF Member in identifying and meeting goals for integrated employment and community integration;
4. Assist Members with identifying natural supports to help meet the Member’s life goals;
5. Will meet face to face with Members in accordance to the minimum contact schedule as outlined by TennCare;
6. Review the PCSP, as applicable to ensure that ECF CHOICES services furnished are consistent with the nature and severity of the Member’s disability and to determine the appropriateness and adequacy of care and achievement of outcomes and objectives outlined in the PCSP, as
applicable;

7. Develop a Safety Plan with the Member and appropriate caregivers. The Safety Plan will be included in the PCSP and must include, at a minimum, detailed and (reading level) appropriate instructions on who to contact in case of an emergency;

8. Review with the Member and appropriate caregivers on a regular basis the Safety Plan and ensure that all contact information is current;

9. Be available by telephone through an answered office telephone during normal business hours (to be specified to Member);

10. Be available by cell telephone/pager outside of normal business hours* (to be specified to Member);

11. Install appropriate voice message advice on its main office telephone system providing simple instructions for contacting appropriate authorities in emergency situations.

*If the Support Coordination Department does not use a cell telephone/pager system outside of normal business hours, a contract must be implemented with an established emergency response center for after-hours telephone answering.

C. ECF CHOICES Long-Term Services and Supports Providers

Providers are responsible for providing ECF CHOICES HCBS to meet the needs of ECF CHOICES Members in a timely manner according to the Person Centered Support Plan (PCSP). The ECF Provider shall provide covered services to ECF CHOICES Members in accordance with the provisions outlined in their executed Provider Contract. Responsibilities associated with these services include, but are not limited to:

1. Participation in the person-centered support planning process driven by the ECF Member;

2. Collaboration with the Support Coordinator to help ensure the PCSP is implemented timely and convenient for the ECF Member;

3. Upon acceptance of an ECF Member to provide approved services, ensure that sufficient staffing is in place to support the amount, frequency, duration and scope of each ECF service;

4. Initiation of ECF CHOICES HCBS within the time frame prescribed in the authorized PCSP;

5. Signing the Member’s PCSP indicating understanding and agreement to Provider and deliver care to ECF Members without deviation unless approved by the Contractor;

6. Continuity of Provider services to the ECF Member when a Provider change is initiated, in accordance to the PCSP until the ECF Member has been transitioned to a new Provider;

7. Use of EVV system for applicable services (process to monitor ECF CHOICES HCBS using electronic visit verification (EVV) for the TennCare ECF CHOICES program);

8. Notifying a Member’s Support Coordinator, as expeditiously as warranted by the Member’s circumstances, of any significant changes in the Member’s condition or care, hospitalizations, or recommendations for additional services;

9. Monitoring and immediately addressing service gaps, including back-up staff;

10. Conducting background checks on its employees, subcontractors, and agents, prior to providing services, in accordance with state law and TennCare policy;

11. Ensure staff is adequately trained in accordance to all mandatory training, and providing attestations to such training upon request and during Provider site visits;

12. Report suspected abuse, neglect, and exploitation of ECF Adult Members in accordance with TCA 71-6-103 and report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605;

13. Comply with Department of Intellectual and Developmental Disabilities (DIDD) investigations as prescribed by TennCare protocol;

14. Investigating and reporting reportable events;

15. Compliance with the HCBS Settings Rule detailed in 42 C.F.R 441.301 C (4) – (5);

16. Providing current financial solvency when providing Community Living Supports services; and

17. Reporting ECF events to the Non-Discrimination Compliance Coordinator as applicable.
D. Employment Community First (ECF) Staff Training

Direct Support Professional (DSP)

The topics below are categorized in three ways. 1) The timeframe in which the training must be completed; 2) The type/mode of training (External certifications; Training modules that are required to be completed online via Relias, with the option to incorporate in-person components; and Training modules required to be provided in-person by Providers’ training staff); and 3) Training that is specific to staff providing Employment services.

Training required to be conducted in person applies even if the module is based in Relias online training. For example, the Provider will be expected to conduct a classroom style presentation of the Relias module and incorporate in-person techniques during the module to achieve active engagement and gauge understanding by staff. Additionally, for all topics except external certifications, demonstration of competency is required regardless of methodology utilized (online vs. in-person). Providers will be required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record. These records will be reviewed at least annually.

Trainings required PRIOR to working with a Member:

In-Person Using Archived, Recorded Webinar and Provider Agency-Specific Presentation:

1. Introduction to Employment and Community First CHOICES for Direct Support Professionals
   Must be completed in-person utilizing:
   b. Presentation by provider agency (minimum 20 minutes) on Provider’s philosophy, approach and experience (if applicable) in delivering ECF CHOICES services. Ideally should include stories of people served (if applicable) with appropriate consents obtained in advance.
   c. At least 15 minutes for Q&A and discussion.

   This training must be the first training module that DSPs complete.

   No exceptions: All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

Relias Modules or In-Person with Demonstrated Competency:

Note: These trainings are listed in the recommended order that DSPs should complete them for logical progression of learning.

1. Disabilities Overview
   Completed in Relias
   Course Description: Everyone has a quality they feel sets them apart. Some of us are tall, some short. Some people have blue eyes, others brown. Some differences between people are called disabilities. This course looks closer at what the term disability means and provides an overview of the different types of disability you are likely to encounter as a direct support Provider, including some of the basic supports people use to further their own independence and participation. Topics include physical and sensory impairments, learning and communication disorders, brain injury, and a section on developmental disabilities. Through interactive lessons, as well as descriptive tools and stories, you will learn how to distinguish different types of impairment and disability and become familiar with their causes, characteristics, and basic
supports appropriate to each. This course is written for direct support professionals who work in
the field of developmental disabilities.

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already
completed this training are required to demonstrate competency prior to supporting a person.
Providers are required to maintain training completion documents with attestation of
demonstrated competency, signed and dated by the employee and the trainer, in the employee's
personnel record.

2. **Title VI Course**
   Completed in Relias
   Course Description: This course explains the laws and expectation related to non-discrimination.

   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already
   completed this training are required to demonstrate competency prior to supporting a person.
   Providers are required to maintain training completion documents with attestation of
demonstrated competency, signed and dated by the employee and the trainer, in the employee's
   personnel record.

   Professional**
   Completed in Relias
   Course Description: This course defines and discusses professionalism as it relates to direct
   support practice and explains how professionalism is achieved and practiced by people who
   support people with disabilities. In this course, you will learn time-management and organization
   techniques to benefit the efficiency and effectiveness of your professional practice, as well as
   investigate the skills, knowledge, and attitudes you need to be truly skilled and competent in your
   important work.

   **Additional requirement:** Provider will need to enhance the modular training to include Disability
   awareness and cultural competency training, including person-first language; etiquette when
   meeting and supporting a person with a disability; and working with individuals who use
   alternative forms of communication, such as sign language or non-verbal communication, or who
   may rely on assistive devices for communication or who may need auxiliary aids or services in
   order to effectively communicate; and the DSP’s responsibility in promoting healthy lifestyle
   choices and in supporting self-management of chronic health conditions.

   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already
   completed this training are required to demonstrate competency prior to supporting a person.
   Providers are required to maintain training completion documents with attestation of demonstrated
   competency, signed and dated by the employee and the trainer, in the employee’s personnel
   record.

4. **HIPAA: Overview**
   Completed in Relias
   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already
   completed this training are required to demonstrate competency prior to supporting a person.
   Providers are required to maintain training completion documents with attestation of demonstrated
   competency, signed and dated by the employee and the trainer, in the employee’s personnel
   record.
5. **Provisions of Positive Behavior Supports for DSPs Part 1: Overview**
   Completed in Relias
   Course description: In-depth training that covers resilience, coping and relationship skills. Behavioral health challenges related to mental health conditions and positive behavior supports are covered. Applied Behavior Analysis (ABA) provided by a Behavior Analyst is explained emphasizing the importance of documenting and sharing how the plan is working and/or not working.

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

6. **ECF CHOICES Documentation of Service Delivery**
   Completed in-person using training materials provided by MCOs. Intent to load to Relias or similar platform in near future. Minimum expectations:
   - Goals from PCSP (as related to service)
   - Date/hours worked
   - What did the person do today? (what, where, when, how long, etc.)
   - Who was there? (Name of the supports present paid staff at a minimum; include natural supports, friends, etc. if applicable)
   - What did you learn that worked well? What did the person like about the activity/opportunity? What needs to stay the same?
   - What did you learn that did not work well? What did the person not like about the activity/opportunity? What needs to be different?
   - Other observations from today for the next support person(s).

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

7. **Use of the EVV System (For PA/SHC/Respite Providers Only)**
   Must be completed in person using training materials provided by MCOs. Intent to load to Relias or similar platform in near future.
   **Note:** MCOs may use different EVV systems. DSPs may need to be trained on more than one EVV system.

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

8. **TN DIDD Standard Precautions**
   Completed in Relias
   Course description: Course covers OSHA universal/standard precautions and the importance of infection control plans maintained by each agency, proper use of Personal Protective Equipment and proper handwashing.

   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record.
9. **Supporting Individuals with Disabilities During Emergencies**

Completed in Relias

Course description: This course provides information for support staff to help individuals with intellectual or developmental disabilities (IDD) during emergencies. This course discusses ways to prevent and respond to common emergencies. It discusses safety inside and outside of the home and how to respond to natural disaster emergencies.

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record.

10. **ECF CHOICES Abuse and Neglect Prevention, Identification and Reporting, and Critical Incident Management and Reporting**

Completed in-person using training materials provided by MCOs.

Note: Updated version of this training entitled “ECF CHOICES Reportable Event Management” will be distributed by 7/31/17.

Intent to load to Relias or similar platform in near future.

**No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

11. **Training specific to the person/the person’s plan**

Must be completed in person.

Training must involve more than requiring DSP to read the PCSP and sign off that they have read it. If a Provider Plan(s) for Service Implementation have been developed, training should include training on this Plan(s) as well as the PCSP.

**No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this module.

**External Certifications**

1. **First Aid**

Must be completed in person.

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to remain current.

2. **CPR with Abdominal Thrust**

Must be completed in person.

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to remain current.

3. **As Applicable: Medication administration**

This training is completed in person and only required if the DSP will administer medications (when employed by a DIDD contracted agency for applicable service).

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to remain current.

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Trainings Required within Sixty (30) Days of Employment

1. **Employment Support Focused Learning**
   Completed in Relias
   Course description: Understanding how to support an individual with disabilities to obtain and maintain employment is an essential component of your job as a direct support professional. In this course you will learn about why employment is important for people with disabilities and how it affects quality of life. You will learn about the types of employment that are available to people with intellectual and developmental disabilities and the way each of them work. You will be introduced to the members of a typical employment team and how they work together to support employment.

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this training.

2. **Supporting Reasonable Risk-taking Necessary for Personal Growth and Dignity**
   As of 7/12/17, in-person training materials not yet available. Requirement goes into effect when training materials are sent to providers. Training materials will be distributed by 7/31/17. Intent to load updated course to Relias or similar platform in near future.
   Course description: Supporting persons with I/DD to take planned and reasonable risks necessary for personal growth, living a full life, and pursuit/achievement of personal goals.

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this training.

3. **Tennessee Conservatorship**
   Completed in Relias
   Course description: An overview of conservatorship in TN. This course will discuss the authority of conservators and the role they play in the lives of people supported in publicly funded programs. Additionally, this course will discuss alternatives to conservatorship and less restrictive options available to members and their families.

   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record.

Trainings Required within Sixty (60) Days of Employment

1. **People with Disabilities: Building Relationships and Community Membership**
   Completed in Relias but must also include in-person components
   In-person content must be developed using:
   http://www.rtc.umn.edu/docs/Friends_Connecting_people_with_disabilities_and_community_members.pdf

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this training.

2. **Person Centered Planning for Individuals with Developmental Disabilities**
   Completed in Relias
   Course Description: This course is designed to give you the tools you need to incorporate person-centered thinking and planning into your work supporting individuals with developmental
disabilities. In this course, you will learn about what makes person-centered planning different from traditional approaches to developing service plans for individuals with developmental disabilities. You'll learn about the importance of distinguishing between what is important to an individual and what is important for that individual, as well as the importance of teamwork in using the person-centered planning approach. Through interactive lessons, personalized planning strategies, and descriptive examples, you will learn how to implement the person-centered approach to supporting the individuals with developmental disabilities with whom you work. This course is appropriate for entry level to intermediate staff and managers.

**Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record.

3. **Choice Making for People with Intellectual and Developmental Disabilities**
   Completed in Relias
   Course Description: People with intellectual and developmental disabilities (IDD) continue to face barriers to participating as equal members of society. They are often seen as unable to make choices or problem solve in their daily life. As a direct support professional, you have the opportunity to help teach these skills to the individuals you serve, and help them assert their thoughts, desires, and goals. This course provides you with an overview of teaching and supporting the choice-making process for people with IDD. You will also learn how to empower individuals to make choices, about different techniques for offering choice-making, and how to teach problem-solving skills to the people you support. This course is written for direct support professionals and frontline supervisors who support people with IDD.

   **Exception for DSPs who are working in the current DIDD system:** DSPs who have already completed this training are required to demonstrate competency prior to supporting a person. Providers are required to maintain training completion documents with attestation of demonstrated competency, signed and dated by the employee and the trainer, in the employee’s personnel record.

4. **Federal HCBS Setting Requirements and the Importance of the Member's Experience**
   As of 7/1/17, in-person using training materials provided by MCOs. Intent to load to Relias or similar platform in near future.
   
   Course Description: Overview of the HCBS Settings Rule and the impact to service provision for persons supported in publicly funded programs. Review of individual rights and requirements related to implementing and documenting restrictions and the fading of restrictions.

   **No exceptions:** All DSPs working in ECF CHOICES, including DSPs who may also be working in the current DIDD system, are required to complete this training.

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**Job Shadowing**

**Note:** For ECF DSPs Providing Services other than Employment Services. If an ECF DSP is only providing employment services, the ECF DSP only has to complete the shadowing required for employment services.

Job shadowing for the Employment Community First CHOICES (ECF) Direct Support Professional (DSP) shall include a combination of hours that address the ECF DSP’s experience level with people who have intellectual/developmental disabilities (IDD), with ECF services the DSP will be providing, and with the
particular Member(s) the ECF DSP will be supporting. Job shadowing hours shall follow the following guidelines:

**Types of Job Shadowing**

1. **Realistic Job Preview:** Within first week of hire, ECF DSPs new to working with people with IDD should shadow to obtain a realistic job preview: 2-4 hours; minimum 2 hours.
2. **Type of Service:** The ECF DSP new to providing ECF services should shadow in each type of service(s) they will provide: 4-8 hours per service type; minimum 4 hours per service type.
3. **Specific to the Member:** The ECF DSP should job shadow based on the Member(s) that they will begin supporting: 2-4 hours; minimum 2 hours.

**DSP Categories (based on experience)**

1. **New DSP (no experience with people with IDD or ECF):** Needs to complete all three (3) types of job shadowing listed above.
2. **New to ECF service:** Has experience with people with IDD but no ECF experience - Needs to complete #2 & #3 types of job shadowing listed above.
3. **DSP experience as ECF Provider:** Has experience working with people with IDD in ECF services, but no experience specific to the Member(s) to be supported - Needs to complete #3 type of job shadowing listed above.

**Job Shadowing Expectations**

- Ideally, to reduce the amount of job shadowing an ECF DSP needs to complete, the shadowing should be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) serving the specific member(s) to be supported in the type of ECF service(s) that the new ECF DSP will be providing to that Member. For example, if a new ECF DSP shadows for four hours in the service type they will be providing and with the Member(s) they will be supporting, this time can count in meeting the above requirements for both shadowing for Type of Service and shadowing Specific to the Member.
- If the Member(s) to be supported is newly enrolled or new to the Provider, the shadowing shall be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) serving an ECF Member with similar support needs in the type of ECF service(s) that the new ECF DSP will be providing.
- If an ECF Member with similar support needs is not being served by the Provider, the shadowing will be with an experienced ECF DSP (or ECF DSP supervisor who is trained as an ECF DSP) in the type of ECF service(s) that the new ECF DSP will be providing.
- Job shadowing should include shadowing of the delivery of all types of ECF services (non-employment) that the ECF DSP will be assigned to provide.
- If the agency is beginning provision of a new ECF service and does not have an experienced ECF DSP, the agency is expected to use an ECF DSP supervisor who is trained on the ECF service(s) to accompany the ECF DSP to begin the ECF service(s) with the Member, thereby allowing the new ECF DSP to shadow the ECF DSP supervisor who will model quality service provision and support.

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**Staff Employment for Employment Providers**

**Supported Employment: Individual Employment Support**

- Exploration
- Benefits counseling
- Discovery
- Situational observation and assessment
- Job development plan or self-employment plan
- Job development or self-employment start-up

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- Job coaching
  - Job coaching for individualized, integrated employment
  - Job coaching for individualized, integrated self-employment
- Co-worker supports
- Career advancement
- Supported Employment – Small Group Support
- Integrated Employment Path Services

There are core qualifications that all staff providing ECF CHOICES Employment Services must meet. These are addressed in first section below. There are additional requirements for training and/or certification depending on whether the staff are serving in the capacity of Job Coach, Job Developer, Certified Benefits Counselor or Supported Employment Supervisor/Manager. These requirements have been specifically defined to best position ECF CHOICES Employment Services providers to support individuals with ID/DD enrolled in the program in achieving their employment goals.

Please note, effective July 1, 2016, staff who meet the ECF CHOICES qualifications are qualified to provide employment services under the DIDD waivers and as such, do not have to complete any other employment-specific trainings normally required under the DIDD waivers.

CORE REQUIREMENTS

There are basic core qualifications for all staff providing ECF CHOICES employment services. Any staff providing any Employment Service under ECF CHOICES must meet the following qualifications:

- 18 years of age or older
- Effectively read, write and communicate verbally in English, and in the service recipient’s first language if not English and the service recipient is not fluent in English
- Able to read and understand instructions, perform record-keeping and write reports
- GED or high school diploma
- Pass a criminal background check, and not listed on the Tennessee Department of Health Abuse Registry or Tennessee Sexual Offender Registry
- If driving is involved in job duties, valid driver’s license and automobile liability insurance
- If using own vehicle to transport Members, appropriate insurance coverage for this purpose (Note: The provider agency may contribute towards the cost of appropriate insurance coverage to transport Members)
- Completion of DSP required training for the Employment and Community First CHOICES program
- Information/training specific to person(s) being served

While not required, it is preferred that all staff providing Employment and Community First CHOICES employment services have a minimum of six months’ experience working with individuals with ID and/or DD, where the work included teaching skills and/or tasks, preferably in an employment setting.

The following table summarizes what the minimum staff qualifications are for Employment and Community First CHOICES employment services, and the associated trainings and/or certificates required, including the supported employment manager/supervisor, although there isn’t a specific service that corresponds with this position.
<table>
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<tr>
<th>Employment Services</th>
<th>Required Job Type</th>
<th>Minimum staff qualifications/training</th>
<th>Timeframe for meeting minimum qualifications/training successfully</th>
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<tr>
<td>• Exploration</td>
<td>Job Coach</td>
<td>• Meets Job Developer requirements (i.e. holds CESP or ACRE certification); OR</td>
<td>For existing staff (in place as of the date the Provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a Job Coach under the Department of Intellectual and Developmental Disabilities (DIDD) waivers or a Vocational Rehabilitation (VR) Letter of Agreement (LOA), there is a one-year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services. For new hires, the qualifications must be met prior to providing ECF CHOICES services.</td>
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<td>• Situational observation and assessment</td>
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<td>• Training Resource Network, Inc. (TRN) Job Coaching and Consulting: Design, Training and Natural Support online web course PLUS shadowing of existing trained/qualified ECF Job Coach (or a Job Coach trained/qualified under DIDD Waiver/VR if no ECF Job Coach is in place in the local area) for at least four hours in at least three different job coaching situations/work sites (equates to a total of 12 hours of shadowing).</td>
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<td>• Job coaching: individual-wage employment</td>
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<td>• Supported employment</td>
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<tr>
<td>• Integrated employment path services</td>
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<tr>
<th>Employment Services</th>
<th>Required Job Type</th>
<th>Minimum staff qualifications/training</th>
<th>Timeframe for meeting minimum qualifications/training successfully</th>
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<tr>
<td>• Benefits counseling</td>
<td>Certified work incentives counselor (CWIC) or CWIC community partner</td>
<td>• Level 5 suitability clearance <strong>AND</strong> • CWIC certification through Virginia Commonwealth University (VCU) or Cornell <strong>AND</strong> • Ongoing continuing education requirements to maintain CWIC certification</td>
<td>The qualifications must be met prior to providing the Employment and Community First CHOICES benefits counseling service.</td>
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<tr>
<td>• Discovery</td>
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<td>• Job development plan</td>
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<tr>
<td>• Job development</td>
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<tr>
<td>• Career advancement</td>
<td>Job developer</td>
<td>• Association of People Supporting Employment (APSE) certified employment support professional (CESP) certificate received through passing an exam <strong>OR</strong> • ACRE basic employment certificate – the supported employment online certificate series earned through VCU <strong>OR</strong> • ACRE basic employment certificate in community employment with emphasis on customized employment offered by Griffin- Hammis Associates <strong>OR</strong> • ACRE basic employment certificate – college of employment services (CES) plus offered by University of Massachusetts Institute for Community Inclusion <strong>OR</strong> • ACRE national certificate of achievement in employment services earned through University of Tennessee (UT) <strong>OR</strong> • ACRE professional</td>
<td>For existing staff (in place as of the date the Provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a Job Developer (Employment Specialist) under a Vocational Rehabilitation (VR) Letter of Agreement (LOA), there is a one-year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services. For new hires qualifying as a Job Developer through the CESP, the CESP qualification must be obtained prior to providing ECF CHOICES services. For new hires qualifying as a Job Developer through ACRE certification, the first four (4) weeks of the ACRE course must be completed prior to...</td>
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<td>Employment Services</td>
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<td>Minimum staff qualifications/training</td>
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<td>employment certificate earned through completion of &quot;Work Works&quot; online course offered by University of Georgia Institute on Human Development and Disability</td>
<td>providing ECF CHOICES services AND the entire ACRE course must be successfully completed (certification obtained and copy provided to each MCO) in order to continue to provide ECF CHOICES services. Additionally, all work done with ECF CHOICES members prior to the successful completion of the entire ACRE course must be monitored, with written products reviewed and approved via co-signature, by a qualified Job Developer (Employment Specialist) or Supported Employment Program Manager.</td>
</tr>
<tr>
<td></td>
<td>Job developer</td>
<td>Association of People Supporting Employment (APSE) Certified Employment Support Professional (CESP) Certificate received through passing exam; OR ACRE Basic Employment Certificate – The Supported Employment Online Certificate Series earned through Virginia Commonwealth University; OR ACRE Basic Employment Certificate in Community Employment with Emphasis on Customized Employment offered by Griffin-Hammis Associates; OR ACRE Basic Employment Certificate - College of Employment Services (CES) Plus offered by University of Massachusetts Institute for Community Inclusion; OR</td>
<td>For existing staff (in place as of the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services) who are qualified as a Job Developer (Employment Specialist) under a Vocational Rehabilitation (VR) Letter of Agreement (LOA), there is a one-year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the Provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services.</td>
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<tr>
<td>Employment Services</td>
<td>Required Job Type</td>
<td>Minimum staff qualifications/training</td>
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<td></td>
<td>Job coach</td>
<td>ACRE National Certificate of Achievement in Employment Services earned through University of Tennessee; OR ACRE Professional Employment Certificate earned through completion of &quot;Work Works&quot; online course offered by University of Georgia Institute on Human Development and Disability. AND Relias ten modules on Customized Self-Employment developed by Griffin-Hammis Associates.</td>
<td>For new hires qualifying as a Job Developer through the CESP, the CESP qualification must be obtained prior to providing ECF CHOICES services. For new hires qualifying as a Job Developer through ACRE certification, the first four (4) weeks of the ACRE course must be completed prior to providing ECF CHOICES services. AND the entire ACRE course must be successfully completed (certification obtained and copy provided to each MCO) in order to continue to provide ECF CHOICES services. Additionally, all work done with ECF CHOICES Members prior to the successful completion of the entire ACRE course must be monitored, with written products reviewed and approved via co-signature, by a qualified Job Developer (Employment Specialist) or Supported Employment Program Manager. For existing staff (in place as of the date the provider is first</td>
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- Job coaching self-employment

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<thead>
<tr>
<th>Employment Services</th>
<th>Required Job Type</th>
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<td></td>
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<td>CESP or ACRE certification) PLUS Relias ten modules on Customized Self-Employment developed by Griffin-Hammis Associates; OR Training Resource Network, Inc. (TRN) Job Coaching and Consulting: Design, Training and Natural Support on-line web course PLUS shadowing of existing trained/qualified ECF Job Coach (or a Job Coach trained/qualified under DIDD Waiver/VR if no ECF Job Coach is in place in the local area) for at least four hours in at least three different job coaching situations/work sites (equates to a total of 12 hours of shadowing) PLUS Relias ten modules on Customized Self-Employment developed by Griffin-Hammis Associates.</td>
<td>credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services who are qualified as a Job Coach under the Department of Intellectual and Developmental Disabilities (DIDD) waivers or a Vocational Rehabilitation (VR) Letter of Agreement (LOA), there is a one-year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES employment services. For new hires, the qualifications must be met prior to providing ECF CHOICES services.</td>
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<td>XXIII-33</td>
<td>Supported Employment Program manager/supervisor of job coaches and job developers</td>
<td>• ACRE professional employment certificate earned through completion of “Work Works” online course offered by University of Georgia Institute on Human Development and Disability OR • Certified rehabilitation counselor (CRC status) and meeting continuing education requirements to maintain the CRC designation • ACRE professional</td>
<td>• For existing program managers/supervisor s in place at the start of Employment and Community First CHOICES, there is a one-year grace period to obtain the qualifications. The one-year grace period is one calendar year from the date the Provider is first credentialed by at least one ECF CHOICES MCO to provide ECF CHOICES services.</td>
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<tr>
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<td></td>
<td></td>
<td>employment certificate (UT)</td>
<td>provide ECF CHOICES employment services.</td>
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<td></td>
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<td>• For new hires, the qualifications must be met within six (6) months of hire.</td>
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VI. ECF CHOICES Provider Agreement
Requirements

Each Provider agency must sign the BlueCare Tennessee Employment and Community First CHOICES Provider Agreement, and a properly executed copy must be on file with the BlueCare Tennessee Provider Relations Division.

Definitions:

“BCT Provider Administration Manual” or “Provider Manual” - The manual contained on the BCT website at http://bluecare.bcbst.com, the terms and conditions of which are incorporated by reference herein and made a part hereof, and which contain information, including, but not limited to, operating policies and procedures as established by BCT for health care and non-health care Providers based upon individual Participation Criteria.

“ECF CHOICES Groups (Group)” – One of the three groups of TennCare enrollees who are enrolled in ECF CHOICES. All groups in ECF CHOICES receive services in the community. These Groups are:

Group 4 (Essential Family Supports) - Children under age twenty one (21) with I/DD living at home with family who meet the NF LOC and need and are receiving HCBS as an alternative to NF Care, or who, in the absence of HCBS, are “At risk of NF placement;” and adults age 21 and older with I/DD living at home with family caregivers who meet the NF LOC and need and are receiving HCBS as an alternative to NF care, or who, in the absence of HCBS, are “At risk of NF placement,” and elect to be in this group. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like, Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

Group 5 (Essential Supports for Employment and Independent Living) - Adults age twenty-one (21) and older I/DD who do not meet nursing facility level of care, but who, in the absence of HCBS are “At Risk” of nursing facility placement. To qualify in this group, the adult must be SSI eligible or qualify in the Interim ECF CHOICES At-Risk Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES At-Risk or ECF CHOICES Working Disabled Demonstration Groups.

Group 6 (Comprehensive Supports for Employment and Community Living) - Adults age twenty-one (21) and older with I/DD who meet nursing facility level of care and need and are receiving specialized services for I/DD. To qualify in this group, an individual must be SSI eligible or qualify in the ECF CHOICES 217-Like Demonstration Group, or upon implementation of Phase 2, the ECF CHOICES Working Disabled Demonstration Group.

Group 7 (Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFCTSS) (children under age twenty one (21) who live at home with family caregivers and have I/DD and severe co-occurring behavioral health and/or psychiatric conditions that place the child or others at significant risk of harm, threaten the sustainability of the family living arrangement, and place the child at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration).

Group 8 Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) is targeted primarily to providing short-term intensive 24/7 community-based behavioral-focused transition and stabilization services and supports to assist adults aged 18 years and older with intellectual and/or developmental disabilities (I/DD) and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities.

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“ECF CHOICES Member” or “Member” - A TennCare enrollee who: (i) has been enrolled by TennCare into ECF CHOICES; and (ii) is enrolled with BCT under the provision of the CRA.

“Clean Claim” - A claim received by BCT for adjudication that requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by BCT.

“Community-Based Residential Alternatives to Institutional Care (CBRA)” - For purposes of CHOICES and ECF CHOICES:

a) Residential services that offer a cost-effective, community-based alternative to nursing facility care for individuals who are elderly and/or adults with physical disabilities and for individuals with I/DD.

b) CBRAs include, but are not limited to:
   i) services provided in a licensed facility such as assisted care living facilities and critical adult care homes, and residential services provided in a licensed home or in the person’s home by an appropriately licensed Provider such as Community Living Supports and Community Living Supports-Family Model; and
   ii) Companion care.

“Community Living Supports (CLS)” - A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to four individuals living in a home that supports each resident’s independence and full integration into the community, ensures each resident’s choice and rights, and comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to Provider-owned or controlled homes, as applicable, including any exception as supported by the individual’s specific assessed need or initial SP, as applicable.

“Community Living Supports – Family Model (CLS-FM)” - A community-based residential alternative service for seniors and adults with disabilities that encompasses a continuum of support options for up to three individuals living in the home of trained family caregivers (other than the individual’s own family) in an adult foster care arrangement. In this type of shared living arrangement, the Provider allows the individual(s) to move into his or her existing home in order to integrate the individual into the shared experiences of a home and a family, and provide the individualized services that support each resident’s independence and full integration into the community, ensure each resident’s choice and rights, and support each resident in a manner that comports fully with standards applicable to HCBS settings delivered under section 1915(c) of the Act, including those requirements applicable to Provider-owned or controlled homes, as applicable, including any exception as supported by the individual’s specific assessed need or initial SP, as applicable.

“Consumer-Directed Worker (Worker)” – An individual who has been hired by a CHOICES or ECF CHOICES Member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or his/her representative to provide one or more eligible CHOICES or ECF CHOICES HCBS to the Member. Worker does not include an employee of an agency that is being paid by an MCO to provide HCBS to the Member.

“Consumer Direction of Eligible CHOICES or ECF CHOICES HCBS” – The opportunity for a CHOICES or ECF CHOICES Member assessed to need specified types of CHOICES or ECF CHOICES HCBS including for purposes of CHOICES, attendant care, personal care, in-home respite, companion care; and for purposes of ECF CHOICES, personal assistance, supportive home care, hourly respite, and community transportation; and/or any other service specified in TennCare rules as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of
the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer-directed workers delivering the needed service(s) and for ECF CHOICES, the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service.

“Contract Provider” – A Provider that is employed by or has signed a provider agreement with the CONTRACTOR to provide Covered Services.

“Contractor Risk Agreement (CRA)” – The Contract between the CONTRACTOR and TENNCARE regarding requirements for operation and administration of the managed care TennCare program, including CHOICES and ECF CHOICES.

“Dispute Resolution Process” – The processes set forth in the Provider Manual to resolve disputes between the parties, including the Provider Dispute Resolution Process and the Medical Management Corrective Action Plan. In addition, the TennCare Provider Independent Review of Disputed Claims process shall be available to Providers to resolve claims denied in whole or in part by BCT as provided at Tenn. Code Ann. § 56-32-126(b).

“Electronic Visit Verification (EVV) System” – An electronic system that meets the minimum functionality requirements prescribed by TENNCARE which provider staff must use to check-in at the beginning and check-out at the end of each period of service delivery to monitor Member receipt of specified CHOICES and ECF CHOICES HCBS and which may also be utilized for submission of claims. Any such system shall comply with the 21st Century Cures Act.

“Eligible ECF CHOICES HCBS” – Personal assistance, supportive home care, hourly respite, community transportation, and/or any other ECF CHOICES HCBS specified in TennCare rules as eligible for consumer direction which an ECF CHOICES Member is determined to need and elects to direct and manage (or have a representative direct and manage) certain aspects of the provision of such services—primarily the hiring, firing and day-to-day supervision of consumer-directed workers delivering the needed service(s) and the delivery of each eligible ECF CHOICES HCBS within the authorized budget for that service. Eligible ECF CHOICES HCBS do not include home health, private duty nursing services, or Intensive Behavioral Family-Centered Treatment, Stabilization and Supports (IBFCTSS).

“Employer of Record” – The Member participating in consumer direction of eligible CHOICES or ECF CHOICES HCBS or a representative designated by the Member to assume the consumer direction of eligible CHOICES or ECF CHOICES HCBS functions on the Member's behalf.

“Employment and Community First (ECF) CHOICES” – A managed long-term services and supports program that offers home and community-based services to eligible individuals with intellectual and developmental disabilities enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

“Home and Community-Based Services” (HCBS) – Services that are provided pursuant to a Section 1915(c) waiver or the CHOICES or ECF CHOICES program as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or to delay or prevent placement in a nursing facility. HCBS may also include optional or mandatory services that are covered by Tennessee's Title XIX state plan or under the TennCare demonstration for all eligible enrollees, including home health or private duty nursing. However, only CHOICES and ECF CHOICES HCBS are eligible for Consumer Direction. CHOICES and ECF CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a ECF CHOICES Member’s needs can be safely met in the community within his or her individual cost neutrality cap. The cost of home health and private duty nursing shall also be counted against the
Member’s Expenditure Cap for Members in ECF CHOICES Group 6 who are granted an exception to the Expenditure Cap based on exceptional medical and/or behavioral needs.

“Integrated Support Coordination Team (IST)” – For purposes of ECF CHOICES Groups 7 and 8, the team consisting of the Member's Support Coordinator and the Behavior Supports Director as defined in 2.29.1.3.6 or a similarly qualified behavior supports professional, who shall be responsible for performing in close collaboration the required Support Coordination functions as specified in this Contract, including (but not limited to) comprehensive initial and ongoing assessments, development and implementation of the PCSP, monitoring progress and outcomes, and transition planning.

“Interagency Review Committee” – The committee composed of staff from TennCare and DIDD that reviews requests submitted on behalf of a Potential Applicant in order to determine whether the Potential Applicant meets reserve capacity criteria as defined in TennCare Rule 1200-13-01-.02 or in Operational Procedures submitted to CMS. Except for individuals with ID or DD who have an Aging Caregiver or as otherwise specified by TennCare, a determination by the Interagency Review Committee that a Potential Applicant meets reserve capacity criteria shall be required before DIDD or an MCO proceeds with an enrollment visit to determine if the Potential Applicant qualifies to enroll in ECF CHOICES in a reserve capacity slot designated for such purpose.

“Long-Term Care Ombudsman Program” – A statewide program for the benefit of individuals residing in long-term care facilities, which may include nursing homes, residential homes for the aged, assisted care living facilities, and community-based residential alternatives developed by the State. The Ombudsman is available to help these individuals and their families resolve questions or problems. The program is authorized by the federal Older Americans Act and administered by the Tennessee Commission on Aging and Disability (TCAD).

“Medical Necessity” or “Medically Necessary” - Medical Necessity and Medically Necessary as used in this Agreement shall have the meaning contained in Tenn. Code Ann. § 71-5-144 and TennCare Rule 1200-13.16.

“Medical Records” – All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“Mental Health Services” – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

“Non-Contract Provider” – Any Provider that is not directly or indirectly employed by or does not have a provider agreement with the CONTRACTOR or any of its subcontractors pursuant to the Contract between the CONTRACTOR and TENNCARE.

“Non-Reportable Event” - An event as defined at Section A.2.12.21 which the contracted Provider is not required to report to the CONTRACTOR or DIDD, but which the Provider shall be responsible for documenting, addressing, tracking and trending in order to prevent similar occurrences in the future whenever possible.

“Prior Authorization” - The act of authorizing specific services or activities before they are rendered or occur.

“Reportable Event” – For the purposes of ECF CHOICES, a Reportable Event is an event that is classified as Tier 1, Tier 2, or Tier 3, as defined by TENNCARE, that the contracted Provider,
CONTRACTOR, or FEA staff shall be responsible for reporting to the CONTRACTOR and/or DIDD, as specified by TENNCARE. The contracted Provider, CONTRACTOR, and/or DIDD, as applicable, shall be responsible for managing, tracking and trending in order to prevent similar occurrences in the future whenever possible as is further detailed in Section A.2.15.7.6 of this CRA.

“Self-Direction of Health Care Tasks” – A decision by a CHOICES or ECF CHOICES Member participating in consumer direction to direct and supervise a paid worker delivering eligible CHOICES or ECF CHOICES HCBS in the performance of healthcare tasks that would otherwise be performed by a licensed nurse. Self-direction of health care tasks is not a service, but rather healthcare-related duties and functions (such as administration of medications) that a CHOICES or ECF CHOICES Member participating in consumer direction may elect to have performed by a consumer-directed worker as part of the delivery of eligible CHOICES or ECF CHOICES HCBS s/he is authorized to receive.

“Service Agreement” – The agreement between a CHOICES or ECF CHOICES Member electing consumer direction of HCBS (or the Member’s representative) and the Member’s consumer-directed worker that specifies the roles and responsibilities of the Member (or the Member’s representative) and the Member’s worker.

“Support Coordinator” The individual who has primary responsibility for performance of support coordination activities for an ECF CHOICES Member as specified in the CRA and who meets the qualifications specified in the CRA.

Requirements:
1. The Provider will provide only those services that the Provider is duly licensed, credentialed, and professionally/technically qualified to provide and will otherwise abide by the terms of an executed Agreement and any applicable attachments. The Provider will use its best efforts to provide Covered Services in a competent and timely manner. In addition, the Provider agrees to provide services in accordance with the terms of their executed agreement and pursuant to the Member approved, written PCSP.
2. The Provider will be issued a copy of the Member’s PCSP and agrees to provide the Covered Services as noted in the PCSP.
3. All Providers shall ensure that services provided are ordered in the PCSP. Each PCSP shall describe the products or services to be furnished, the frequency and duration of each product or service, and the Provider type required to furnish each product or service. All services shall be furnished pursuant to an approved written, PCSP. The Provider shall not bill BlueCare Tennessee or the Member, for products or services furnished prior to the issuance of the PCSP or products or services not included in the PCSP.
4. The Provider shall be prohibited from requiring a Member to choose the Provider as a provider of multiple products or services as a condition of providing any service.
5. Provider is prohibited from soliciting Members to receive services from the Provider including: (i) referring an individual for CHOICES or ECF CHOICES screening and intake with the expectation that, should CHOICES or ECF CHOICES enrollment occur, the Provider will be selected by the Member as the service Provider; or (ii) communicating with existing CHOICES or ECF CHOICES Members via telephone, face-to-face or written communication for the purpose of petitioning the Member to change Providers; and (iii) communicating with hospitals, discharge planners or other institutions for the purposes of soliciting potential CHOICES or ECF CHOICES Members that should instead be referred to the person’s MCO or Area Agency on Aging and Disability, or DIDD, as applicable.
6. Provider shall provide advance written notice to BlueCare Tennessee before voluntarily terminating the agreement and specify the timeframe for providing such notice.
7. Provider shall notify BlueCare Tennessee immediately if Provider is considering discharging a Member. Provider must consult with the Member’s Support Coordinator to intervene in resolving the
issue if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate.

8. Provider shall notify the Member in writing prior to discharge in accordance with state and federal requirements.

9. Provider shall accept payment or appropriate denial made by BlueCare Tennessee (or, if applicable, payment by BlueCare Tennessee that is supplementary to the Member’s third party payer) plus the amount of any applicable patient liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable patient liability responsibilities. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Member being served.

10. The Provider shall assure that all applicable standards of any licensure or certification requirements are met. All Providers shall be at least eighteen (18) years of age and shall not have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare Program.

11. ECF CHOICES HCBS Providers must submit copies of current licensure and/or certification (as applicable) to BCT.
   • For CLS1 and CLS2 services, the Provider is required to be licensed by DIDD as a ID & DD Semi-Independent Living Services Facility in accordance with licensure regulations.
   • For CLS3 services, the Provider is required to be licensed as a ID & DD Supported Living or Residential Habilitation Facilities Provider by DIDD in accordance with licensure requirements.
   • For all CLS and CLS-FM services, the Provider is required to be licensed by DIDD as ID & DD Placement Services Facility in accordance with licensure regulations, and must also be contracted with DIDD to provide residential services in at least one of the State’s 1915 waivers for individuals with intellectual disabilities, and actively providing residential services.

12. The Provider, unless it is a subdivision of the State of Tennessee, and any subcontractor retained for the purpose of providing any services shall secure all necessary liability and worker’s compensation insurance coverage as necessary to adequately protect Members and BCT under an executed Provider Agreement.

13. All Providers utilizing the EVV System shall have adequate EVV staff to monitor the EVV System on a daily basis. At a minimum, such Provider shall have at least one full time staff person devoted to EVV System monitoring and two staff persons fully trained and knowledgeable of the EVV System and its functionality. Additionally, such Provider shall ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and in a manner previously approved by TennCare.

14. The Provider shall notify BCT in writing at least sixty (60) days prior to the date of the proposed termination of services to the Member.

15. The Provider shall have written procedures for the provision of language assistance services to Members and/or the Member’s representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats for any Member and/or the Member’s representative who need such services, including but not limited to, Members with Limited English Proficiency and individuals with disabilities.

16. Provider is prohibited from reproducing for its own use the CHOICES or MFP logos unless Provider has submitted a request to BCT to do so and BCT has obtained prior written approval from TennCare in accordance with Section A.2.17 of the CRA.

“Person Centered Support Plan (PCSP)” – Person Centered Support Plan (PCSP) – As it pertains to ECF CHOICES, the PCSP is a written plan developed by the Support Coordinator in accordance with Section A.2.9.6.6.2, using a person-centered planning process that accurately documents the Member’s strengths, needs, goals, lifestyle preferences and other preferences and outlines the services and supports that will be provided to the Member to help them achieve their preferred lifestyle and goals, and
to meet their identified unmet needs (after considering the availability and role of unpaid supports provided by family members and other natural supports) through paid services provided by the CONTRACTOR and other payor sources). The initial planning process is directed by the Member with long-term support needs unless he or she has a court-appointed guardian or conservator, and may include a representative whom the Member has freely chosen to assist the Member with decision-making, and others chosen by the Member to contribute to the process. This planning process, and the resulting PCSP, will assist the Member in achieving a personally defined lifestyle and outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health, welfare, and personal growth.

“System of Support (SOS)” – A comprehensive person-centered approach to the delivery of Behavioral Crisis, Prevention, Intervention, and/or Stabilization services (see Section A.2.7.2.8.4) for individuals with I/DD who experience challenging behaviors that place them and/or others at risk of harm with a primary focus on coordination of services and supports, improved linkages, and increased capacity of paid and unpaid caregivers to prevent, stabilize, and manage crisis events in order to empower individuals with I/DD to live the lives they want in their communities.

“Tennessee Department of Intellectual and Developmental Disabilities ” or “DIDD” – The state agency having the statutory authority to plan, promote, provide and support the delivery of services for persons with intellectual and developmental disabilities, and which serves as the contracted operating agency for the state’s 1915(c) HCBS Waivers and is responsible for the performance of contracted functions for ECF CHOICES as specified in interagency agreement.
VII. ECF CHOICES Provider Contracting/ Credentialing

BlueCare Tennessee’s ECF CHOICES program for Employment and Community First Services ensures that all contracted Providers are initially credentialed and re-credentialed to remain network ECF CHOICES Providers. The process meets the minimum NCQA requirements as specified in the NCQA Standards and Guidelines for the Accreditation of MCOs. In addition, BlueCare Tennessee ensure that all ECF Providers, including those credentialed/re-credentialed in accordance with NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations (MCOs), meet applicable State requirements, as specified by TENNCARE in State Rule, the Contractor Risk Agreement (CRA), or in policies or protocols.

Credentialing occurs initially during the application process for any ECF CHOICES Provider applying to participate in the ECF CHOICES Network. Once a Provider is approved to participate in the network, they must be re-credentialed based on the service types that each ECF CHOICES Provider provides. For ongoing ECF CHOICES Providers, they must be re-credentialed at least annually: Employment Services and Supports, Benefits Counseling, Community Integration Supports Services, Community Transportation, Independent Living Skills Training, Personal Assistance, Community Living Supports, Community Living Supports Family-Model, Specialized Consultation and Training, Respite, Supportive Home Care, Peer-to-Peer Self Direction, Community Support Development, Organization and Navigation, Conservatorship and Alternatives to Conservatorship, Health Insurance Counseling (Forms Assistance) and Family to Family Support. All other ECF CHOICES Providers (minor home modifications, and assistive technology) must be re-credentialed, at a minimum, every three (3) years.

ECF CHOICES Providers that are contracted and enrolled in the network must be compliant with the HCBS Settings Rule and Person-Centered Planning to ensure Medicaid-funded HCBS are provided in settings that are non-institutional in nature. BlueCare Tennessee ensures that contracted Providers deploy services that reflect Member needs, preferences, and goals. Through credentialing of first time Providers, and re-credentialing of established Providers, BlueCare Tennessee ensures that HCBS settings core indicators are met and sustained. The standards that are measured and are requirement for compliance, network entrance and retention are:

1. **Integration** in the greater community.
2. **Choice** of service settings and Providers that provide the services in the setting.
3. **Rights** to privacy, dignity, respect and freedom from coercion.
4. **Independence** that optimizes personal initiative and autonomy.

Compliance for the HCBS Setting Rule is measured during the mandatory credentialing schedule and conducted on-site visit. Providers must demonstrate ongoing compliance to these rules and confirm with signature through attestation on the Standards Assessment and Documentation Review Tool.

Providers must complete the web-based new Provider orientation on DIDD Quality Monitoring processes and expectations of ECF CHOICES services monitored by DIDD as part of orientation.

MCOs are required to maintain a network of contracted providers for ECF CHOICES that is adequate to ensure choice of Providers, to meet the needs of each and every Member enrolled in the program, and to provide authorized ECF CHOICES HCBS. This includes initiating services in the Member’s person centered supports plan within the prescribed timeframes specified in the contract and in ECF CHOICES protocols, and continuing services in accordance with the Member’s person centered supports plan, including the amount, frequency, duration and scope of each service in accordance...
with the Member’s service schedule. The following are “preferred contracting standards” that MCOs will apply in contracting with providers for ECF CHOICES:

- The Provider currently participates in one or more of the Section 1915(c) waiver programs for individuals with I/DD, and has a consistent Quality Assurance (QA) performance rating of “proficient” or “exceptional performance.” Providers with “exceptional performance” shall be given additional consideration. For the purpose of this Section, consistent QA performance shall mean that the provider receives the ratings of performance described above for at least two (2) consecutive years, including the most recent survey results.

- The Provider has or is actively seeking (meaning applied for and has financially invested in the process) accreditation from a nationally recognized accrediting body, e.g., Commission on Accreditation of Rehabilitation Facilities (applicable only if accredited for the specific services the Provider will provide in ECF CHOICES), Council on Quality and Leadership (CQL), and the Council On Accreditation (COA). Acceptance of accreditation from other entities not listed must be prior approved by TENNCARE.

- The Provider has a Vocational Rehabilitation Letter of Agreement with the Tennessee Department of Human Services, Division of Rehabilitation Services.

- The Provider has completed DIDD person-centered organization training.

- The Provider has achieved documented success in helping individuals with I/DD achieve employment opportunities in integrated community settings at a competitive wage. Such success may be based on the number or percent of persons served that the Provider has successfully placed in integrated employment settings who are earning a competitive wage; success in developing customized employment options for individuals with more significant physical or behavior support needs; or other employment successes the CONTRACTOR determines merit additional contracting consideration;

- The Provider has demonstrated leadership in employment service delivery and community integration, e.g., designing and implementing plans to transition away from facility-based day services to integrated employment services with community-based wraparound supports.

- The Provider can demonstrate longstanding community relationships that can be leveraged to assist Members in pursuing and achieving employment and integrated community living goals, including commitments from such community-based organizations to work with the Provider in order to help persons supported by the Provider to achieve such goals.

- The Provider has assisted persons supported by the agency in successfully transitioning into more independent living arrangements, such as Semi-Independent Living.

- The Provider has policies and systems in place to support Member selection of staffing and consistent staffing assignment, which are implemented and monitored.

- The Provider has capacity and willingness to function as a health partner with choice agency in order to support Member participation in staff selection and supervision, including appropriate clinical and case management staffing to support ongoing assurance of appropriate preventive care and management of chronic conditions.

- The Provider is willing and able to assign staff who are linguistically competent in spoken languages other than English that may be the primary language of individuals enrolled in ECF CHOICES and/or their primary caregivers. The Provider is able to assign staff that are trained in
the use of auxiliary aids or services in order to achieve effective communication with individuals enrolled in ECF CHOICES and/or their primary caregivers.

- The Provider employs a Certified Work Incentive Coordinator (CWIC) who is available to counsel Members on benefits and employment.

- The Provider employs or contracts with appropriately licensed professionals in one (1) or more specialty areas (behavior services, occupational therapy, physical therapy, speech language pathology, nutrition, orientation and mobility, or nurse education, training and delegation) to assist paid staff in supporting individuals who have long-term intervention needs, consistent with the ISP, therefore increasing the effectiveness of the specialized therapy or service, and allows such professionals to be an integral part of the person-centered planning team, as needed, to participate in team meetings and provide additional intensive consultation for individuals whose functional, medical or behavioral needs are determined to be complex.

- The Provider meets other standards established by TennCare in policy or protocol that are intended to confer preferred contracting status.

Credentialing of ECF Providers shall include the collection of required documents and verification that the Provider:

1. Has a valid license or certification for the services it will contract to provide as required pursuant to State law or rule, or TENNCARE policies or protocols;
2. Attained an acceptable outcome for recent inspections or monitoring from licensing agencies as applicable;
3. Is not excluded from participation in the Medicare or Medicaid programs;
4. Has a National Provider Identifier (NPI) Number, where applicable, and has obtained a Medicaid provider number from TENNCARE;
5. Possesses General and/or Professional Liability insurance with acceptable limits;
6. Has policies and processes in place to conduct and evaluate, in accordance with federal and state law and rule and TENNCARE policy, criminal background checks, which shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE), on all prospective employees who will deliver ECF CHOICES HCBS and to document these in the worker’s employment record; Additionally, has policies and procedure to check the LEIE monthly on an ongoing basis for each worker; also has within the policy that screening of employees and contractors occur prior to the performance of their duties and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The Provider shall also be required to have an individual assessment policy for assessing potential employees whose criminal background check reveals past criminal conduct of the kind not subject to exclusion or debarment by state and federal law. The Provider shall be required to immediately report to BlueCare Tennessee any exclusion information discovered. The Provider shall be informed by BlueCare Tennessee that civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare Members; and
7. Has a process in place to provide and document initial and ongoing education to its employees who will provide services to ECF CHOICES Members that includes, at a minimum:
   - Orientation to the population that the staff will support (elderly and disabled population; adults with physical disabilities, individual with I/DD);
   - Disability awareness and cultural competency training, including person-first language etiquette when meeting and supporting a person with a disability;

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• Ethics and confidentiality training, including HIPPA and HI-TECH;
• Delivering person-centered services and supports, including Federal HCBS setting requirements and the importance of the Member’s experience;
• Working with family members and/or conservators, while respecting individual choice;
• An introduction to behavioral health, including behavior support challenges, individuals with I/DD or other cognitive limitations (including Alzheimer’s disease, dementia, etc);
• The paid caregiver’s responsibility in promoting healthy lifestyle choices and in supporting self-management of chronic health conditions;
• Abuse, neglect and exploitation prevention, identification and reporting;
• Reportable event identification management and reporting;
• Documentation of service delivery;
• Deficit Reduction Act information regarding False Claim Act and detecting fraud, waste and abuse;
• Community Living Supports;
• Use of the EVV System; and
• Any other training requirements specified by TENNCARE in State Rule, or in policies or protocols.

8. Has policies and processes in place to ensure:
• Compliance with BlueCare Tennessee’s reportable event reporting and management process;
• Appropriate use of the EVV system;
• Documentation, retention and disclosure of enrollee specific data;
• Documentation, retention and disclosure of service delivery;
• Deficit Reduction Act: False Claim Act and detecting fraud, waste and abuse;
• Community Living Supports; and
• Compliance with the Person-Centered Planning and HCBS Setting Rule.

At a minimum, re-credentialing of ECF Providers shall include verification of continued licensure and/or certification (as applicable), and compliance with policies and procedures identified during credentialing, including background checks, LEIE and other registry checks, training requirements, reportable event reporting and management, and use of the EVV.

For both credentialing and re-credentialing processes, ECF staff shall conduct a site visit. If the Provider is located out of state, BlueCare Tennessee ECF CHOICES may waive the site visit and perform a documentation audit in lieu of the on-site visit documenting the reason in the Provider file. During the site visits conducted for each ECF Provider type, BlueCare Tennessee will document and verify compliance with all requested documentation. The tools used to identify potential deficiencies during the credentialing and re-credentialing process include, but are not limited to, the following:
• ECF BlueCare application
• ECF CHOICES Rep Checklist
• ECF CHOICES Enrollment Checklist
• Credential Statement of Attestation for Organizational Providers
• Standards Assessment; and Documentation Review Form

If documents are not available at the time of the on-site audit, BlueCare Tennessee Provider Network Manager records the missing documents in the comment section of the ECF CHOICES Site Visit Report. The Provider will be placed on a Corrective Action Plan (CAP) and will have fourteen (14) days to submit the missing information. The Provider will be instructed to provide the missing documentation and of the obligation to supply the documentation by the due date established at the time of the on-site visit. The Provider may submit documents in the mutually agreed upon manner to include: e-mail, fax, mail or hand-delivery.
If required documents are not submitted timely and/or not acceptable:

- New Providers/initial credentialing: the contract process will end.
- Existing Providers will be placed on a Process Discontinuation Plan and receive a formal letter with a future termination date and re-credentialing will not be granted until all requirements are met.

If during the site visit any deficiencies are identified, the Provider will be required to correct the deficiency and may request the Provider submit a formal corrective action plan (CAP) that addresses the deficiency. Ongoing monitoring of that CAP will continue until all deficiencies have been adequately addressed and are no longer deficient. While a CAP could be requested for any deficiency related to BlueCare Tennessee policies and procedures for credentialing and re-credentialing, it could include any time a Provider does not meet ECF CHOICES minimum requirements and/or deficiencies are identified related to the Provider’s policies, procedures, training and reporting processes.

BlueCare Tennessee Credentialing Committee is responsible for reviewing and approving all initial credentialing and re-credentialing requests. The committee will take into account all information obtained during the credentialing or re-credentialing process to make a final decision. The committee will also review any findings or deficiencies along with an evaluation of the Provider’s corrective actions identified during the credentialing or re-credentialing process to aid in the decision making process. The committee may also take into account any additional grievances against the Provider or performance concerns that have been identified during the course of a Provider’s contract with ECF CHOICES.

The BlueCare Tennessee Provider contract permits either party to terminate the Provider Agreement or any applicable network Attachment with sixty (60) days prior written notice. Final decisions are determined via committee member vote and outcomes are documented in the committee meeting minutes. BlueCare Tennessee furnishes written notification to the Providers regarding the status of the credentialing or re-credentialing process. At a minimum, BlueCare Tennessee shall re-verify monthly that each ECF Provider has not been excluded from participation in the Medicare or Medicaid, and/or SCHIP programs.

**Credentialing Requirements for ECF CHOICES Providers**

**Employment Services/Supports (Annual credentialing)**

- Certified Employment Provider
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Benefits Counseling (Annual credentialing)**

- Licensed CWIC-self-employed or Provider-employed
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

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Community Integrated Support Services (Annual credentialing)
- Licensed Day Habilitation Provider
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Transportation (Annual credentialing)
- Licensed Personal Assistant Provider or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Independent Living Skills Training (Annual credentialing)
- Licensed Day Habilitation Provider
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Personal Assistant (Annual credentialing)
- Licensed Personal Assistant Provider as PSSA, PSSL or Home Care Organization or CD worker
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Community Living Supports & Family Model (Annual credentialing)
- Licensed as a DIDD (SL or ML or Res Habilitation Provider)
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

Assistive Technology (Recredentialing every 3 years)
- Licensed as DME or other wholesale or business entity
- General liability and /or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Minor Home Modification (Recredentialing every 3 years)**
- Licensed as Service Agency, building supplier, contractor, carpenter, craftsman or DME supplier (no subcontractors)
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Specialized Consultation and Training (Annual credentialing)**
- Licensed professional or qualified AT professional
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Respite (Annual credentialing)**
- Licensed as PSSA or PSSL or Home Care Organization or CD worker
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Supportive Home Care (Annual credentialing)**
- Licensed as PSSA or PSSL or Home Care Organization or CD worker
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application

**Intensive Behavioral Community Transition and Stabilization Services (IBCTSS) (Annual credentialing)**
- Licensed personal assistance Providers as PSSA
- Outpatient Mental Health License
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application
Community Support Development, Organization and Navigation (Annual credentialling)

- Licensed as Community Navigator
- General liability and/or malpractice insurance
- Medicaid number and NPI number, if applicable
- Ownership and disclosure of interest statement
- Site Visit
- History of federal and/or state sanctions (Medicare/Medicaid or TennCare)
- Attestation to the accuracy of the application
### VIII. Billing and Reimbursement

**ECF CHOICES-specific billing and reimbursement guidelines**

**NOTE:** All rates are reimbursed at 100 percent of the applicable State ECF CHOICES rate.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>HCPCS/ Modifier</th>
<th>Revenue Code</th>
<th>Description</th>
<th>Consumer Direction</th>
<th>Limit</th>
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<tr>
<td>Exploration - Individual</td>
<td>T2025 UA</td>
<td>969</td>
<td>Unit to be used as o/c based payment unit. Outcome based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written report using standardized template prescribed by TennCare. All required service elements must be completed within 30 calendar days. Written report due no later than 14 calendar days after last date of service (maximum 44 days from service start date).</td>
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<td>1 X every 365 days</td>
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<tr>
<td>Benefits Counseling</td>
<td>T2025 UB T2025 U1 UB T2025 U2 UB</td>
<td>969</td>
<td>Units should be authorized per quarter hour. T2025 UB = up to 20 hours. Can be authorized once every 730 days. T2025 U1 UB = an additional 6 hours. Can be authorized 3/year. T2025 U2 UB = PRN. Up to 8 hours per PRN. Can be authorized 4/year.</td>
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<tr>
<td>Discovery - Individual</td>
<td>T2025 U2</td>
<td>969</td>
<td>Unit to be used as o/c based payment unit. Outcome based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written profile using standardized template prescribed by TennCare. All required service elements must be completed within 90 calendar days. Written report due no later than 14 calendar days after last date of service (maximum 104 days from service start date).</td>
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<td>Situational Observation and Assessment - Individual</td>
<td>T2025 U3</td>
<td>969</td>
<td>Unit to be used as o/c based payment unit. Outcome based payment. MCO may authorize up to 4 units (experiences) within 30 calendar days. Reimbursement may occur after each experience upon receipt of service log (dates; activities; duration of each activity) and acceptable written summary report due within seven calendar days of experience being completed or 30 calendar days of service start date, whichever is sooner. Can be authorized only once every 1095 days.</td>
<td>No</td>
<td>Max 4 units w/in 30 calendar days 1 X every 1095 days</td>
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<td>T2025 U4</td>
<td>969</td>
<td>Unit to be used as o/c based payment unit. Outcome based payment upon receipt of service log (dates; activities; duration of each activity) and acceptable written plan using standardized template prescribed by TennCare. Service must be completed and written plan</td>
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<td>1 X every 1095 days</td>
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<td>Benefits</td>
<td>HCPCS/Modifier</td>
<td>Revenue Code</td>
<td>Description</td>
<td>Consumer Direction</td>
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<td></td>
<td>T2025 UE U3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Employment Start Up</td>
<td>T2025 US UA U1</td>
<td></td>
<td>Unit to be used as o/c based payment unit. Outcome based payment upon service recipient achieving the following milestones: Phase 1. Completing two calendar weeks of individualized, integrated employment; Phase 2. Completing six calendar weeks of individualized, integrated employment; Phase 3. Completing ten calendar weeks of individualized, integrated employment. Tier A: average 80 hours Tier B: average 60 hours Tier C: average 40 hours Payment Phases: Phase 1: 60% of hours Phase 2: 25% of hours Phase 3: 15% of hours</td>
<td>No</td>
<td>1 X every 365 days</td>
</tr>
<tr>
<td></td>
<td>T2025 US UA U2</td>
<td></td>
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<td>T2025 US UA U3</td>
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<td>T2025 US UB U1</td>
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<td>T2025 US UB U2</td>
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<td>T2025 US UB U3</td>
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<td>T2025 US UE U1</td>
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<td>T2025 US UE U2</td>
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<td></td>
<td>T2025 US UE U3</td>
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<tr>
<td>Benefits</td>
<td>HCPCS/Modifier</td>
<td>Revenue Code</td>
<td>Description</td>
<td>Consumer Direction</td>
<td>Limit</td>
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<tr>
<td>U3</td>
<td></td>
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</tr>
<tr>
<td>Job Coaching - Individual-Wage Employment</td>
<td>T2019 and T2018 Refer to authorization</td>
<td>969</td>
<td>Person’s acuity tier must be determined prior to authorization. Three possible acuity tiers. Reimbursement rate based on support hours needed as percentage of the supported employee’s paid work hours and length of time person has held job. One of three rates is possible.</td>
<td>No</td>
<td>Max 40 hrs in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.</td>
</tr>
<tr>
<td>Job Coaching - Individual-Self-Employment</td>
<td>T2019 and T2018 Refer to authorization</td>
<td>969</td>
<td>Person’s acuity tier must be determined prior to authorization. Three possible acuity tiers. Reimbursement rate based on support hours needed as percentage of the supported employee’s paid work hours and length of time person has held job. One of three rates is possible.</td>
<td>No</td>
<td>Max 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.</td>
</tr>
<tr>
<td>Co-Worker Supports</td>
<td>T2019 U1 UB UP</td>
<td>969</td>
<td>Rate based on gross cost to employer for co-worker support (payment to co-worker plus applicable employer taxes), plus a flat .60 Provider admin fee per 15 minute unit of co-worker support.</td>
<td>No</td>
<td>Max 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.</td>
</tr>
<tr>
<td>Career Advancement</td>
<td>T2025 U8 T2025 U9</td>
<td>969</td>
<td>Unit to be used as o/c based payment unit. Two separate outcomes: 1. Written plan submitted and approved; 2. Person achieves career advancement objective and has been in new position or second job for a minimum of 2 weeks. Can be authorized only once every 1095 days. Exception: Only when o/c 1 was paid and o/c 2 was never achieved, o/c 1 and o/c 2 may be reauthorized a second time within 1095 days only if different Provider is used.</td>
<td>No</td>
<td>Unit to be used as o/c based payment unit. Two separate outcomes. Outcome based payment. Can be authorized only once every 1095 days. Exception: Only when o/c 1 was paid and o/c 2 was never achieved. Units may be reauthorized after a</td>
</tr>
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</table>

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<thead>
<tr>
<th>Benefits</th>
<th>HCPCS/ Modifier</th>
<th>Revenue Code</th>
<th>Description</th>
<th>Consumer Direction</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Employment (Small Group - Max of 2 persons)</td>
<td>T2019 U2</td>
<td>969</td>
<td>Habilitation, supported employment, waiver; per 15 minutes</td>
<td>No</td>
<td>Max 30 hours/week in combination with other non-res hab services</td>
</tr>
<tr>
<td>Supported Employment (Small Group - Max of 3 persons)</td>
<td>T2019 U3</td>
<td>969</td>
<td>Habilitation, supported employment, waiver; per 15 minutes</td>
<td>No</td>
<td>Max 30 hours/week in combination with other non-res hab services</td>
</tr>
<tr>
<td>Transition from small group to individual employment - This is an Incentive Payment, not a 'service'.</td>
<td>T2025 U3 UB</td>
<td>969</td>
<td>Unit to be used as one-time incentive payment for successful and complete transition of person from small group SE to individual, integrated employment. Prior to the Provider being eligible for incentive payment, the Member must have a minimum of six months in small group employment support services and a minimum of seven consecutive months in employment in individual employment or self-employment.</td>
<td>No</td>
<td>1 unit per person/per Provider</td>
</tr>
<tr>
<td>Integrated Employment Path Services (Time-Limited Prevocational Training)</td>
<td>T2015 U1 T2015 U2</td>
<td>969</td>
<td>Habilitation, prevocational, waiver; per hour</td>
<td>No</td>
<td>Max 12 months with one possible 12 month extension (see service definition for details) Max 20 hours per week in combination with other non-res hab services; 30 hours in combination with other non-res hab services if receiving at least one employment service; 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.</td>
</tr>
<tr>
<td>Benefits</td>
<td>HCPCS/ Modifier</td>
<td>Revenue Code</td>
<td>Description</td>
<td>Consumer Direction</td>
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<tr>
<td>Community Integration Support Services</td>
<td>T2021 T2021 U1 U1 UA T2028 U1 T2028 U2</td>
<td>969</td>
<td>T2021 and T2021 with modifiers to be used for services provided. T2028 plus modifiers to be used for cost of registration, materials and supplies for participation in classes, conferences, or club/association dues. U1 modifier signifies children under age 21. U2 modifier signifies adults 21+. Allowable costs are maximums.</td>
<td>No</td>
<td>Max 20 hours per week in combination with other non-res hab services; 30 hours in combination with other non-res hab services if receiving at least one employment service; 40 hrs. in combination with other non-res hab if working in individual integrated employment; 50 if employed at least 30 hours in individual integrated employment.</td>
</tr>
<tr>
<td>Independent Living Skills Training</td>
<td>T2021 U2</td>
<td>969</td>
<td>Day habilitation, waiver; per 15 minutes</td>
<td>No</td>
<td>Max 20 hrs. /week in combination with other non-res hab services if not in employment services. Max 30 hours per week in combination with other non-res hab services including at least one employment service (not Individualized Integrated or Self-Employment); Max 40 hrs. / week in combination with other non-res hab services if in individual integrated employment; Max 50 hrs./week in combination with other non-res hab services if working in individual integrated employment at least 30 hours per week.</td>
</tr>
<tr>
<td>Benefits</td>
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<td>Description</td>
<td>Consumer Direction</td>
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<tr>
<td>Personal Assistance</td>
<td>T1019 UA</td>
<td>570</td>
<td>Personal care; per 15 minutes</td>
<td>Yes</td>
<td>215 hours/month applicable to Group 6 only; expenditure cap for Group 5 limits below 215 hrs./month</td>
</tr>
<tr>
<td>Community Transportation</td>
<td>T2002 T2003 UC</td>
<td>960</td>
<td>T2002 – Non-emergency transportation; per diem (for Provider agency use only)</td>
<td>Yes</td>
<td>Cost should be determined prior to authorization and the lesser of the two expenses must be used.</td>
</tr>
<tr>
<td>Community Living Supports (CLS)</td>
<td>CLS 1a T2033</td>
<td>960</td>
<td>1 unit/day</td>
<td>No</td>
<td>1 unit/day</td>
</tr>
<tr>
<td>CLS 1b</td>
<td>U1 UA</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CLS 2</td>
<td>U3 UA</td>
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<tr>
<td>CLS 3</td>
<td>U4 UA</td>
<td></td>
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<tr>
<td>CLS 4</td>
<td>U5 UA</td>
<td></td>
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<td></td>
<td>U6 UA</td>
<td></td>
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<td></td>
<td>U7 UA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Community Living Supports—Family Model (CLS-FM)</td>
<td>CLSFM 1a T2016</td>
<td>960</td>
<td>1 unit/day</td>
<td>No</td>
<td>1 unit/day</td>
</tr>
<tr>
<td>CLSFM 1b</td>
<td>U1 UA</td>
<td></td>
<td></td>
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<tr>
<td>CLSFM 2</td>
<td>U2 UA</td>
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<tr>
<td>CLSFM 3</td>
<td>U3 UA</td>
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<tr>
<td>CLSFM 4</td>
<td>U4 UA</td>
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<tr>
<td></td>
<td>U5 UA</td>
<td></td>
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<tr>
<td></td>
<td>U6 UA</td>
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<thead>
<tr>
<th>Benefits</th>
<th>HCPCS/ Modifier</th>
<th>Revenue Code</th>
<th>Description</th>
<th>Consumer Direction</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Technology, Adaptive Equipment and Supplies</td>
<td>T2029 U4</td>
<td>590</td>
<td></td>
<td>No</td>
<td>$5000/year</td>
</tr>
<tr>
<td>Minor Home Modifications</td>
<td>S5165</td>
<td>590</td>
<td></td>
<td>No</td>
<td>$6,000/project; $10,000/year; $20,000/lifetime</td>
</tr>
<tr>
<td>Individual Education and Training</td>
<td>T2012</td>
<td>969</td>
<td>Units to billed per pre-authorized occurrence of expense.</td>
<td>No</td>
<td>$500/year</td>
</tr>
<tr>
<td>Peer-to-Peer Support and Navigation for Person-Centered Planning, Self-Direction, Integrated Employment/ Self-Employment and Independent Community Living</td>
<td>T2013</td>
<td>969</td>
<td>Face to face and telephonic time can accumulate to equate to hour increments before billing whole hours. First visit must be face to face.</td>
<td>No</td>
<td>$1500/lifetime</td>
</tr>
</tbody>
</table>
| Specialized consultation and training                                    | G0159 G0160 G0161 G0164 S9470 H2015 H2014 G0159 U1 G0160 U1 G0161 U1 G0164 U1 S9470 U1 H2015 U1 H2014 U1 | 942           | G0159 = OT  
G0160 = PT  
G0161 = SLP  
G0164 = RN  
S9470 = Nutritionist  
H2015 = Behavioral Supports  
H2014 = Orientation and Mobility  
U1 modifier will be used for people in Group 6 receiving this service who are determined to have exceptional medical and/or behavioral needs.  
No more than 3 hours for assessment and plan development. Up to no more than 90 minutes per training/consultation session. | No                 | rates up to $5000/year; U1 = 10,000/year if have exceptional needs |
<table>
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<tr>
<th>Benefits</th>
<th>HCPCS/Modifier</th>
<th>Revenue Code</th>
<th>Description</th>
<th>Consumer Direction</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dental</td>
<td>HCPCS currently covered in HCBS waivers</td>
<td></td>
<td>Allowable HCPCS list will be provided separately</td>
<td>No</td>
<td>$5000/year; $7500/three consecutive years</td>
</tr>
<tr>
<td>Respite</td>
<td>S5150 UA S9125 UA S9125 UB</td>
<td>660</td>
<td>Respite to be provided in a person’s home or home of respite worker, not a group residential setting. Modifiers for multiple services in one day (for use with S5150 only): U1, U2, U3, U4, U5</td>
<td>Yes</td>
<td>216 hours/year OR 30 days/year</td>
</tr>
<tr>
<td>Supportive Home Care (SHC)</td>
<td>T1019 U2 T1019 UC</td>
<td>570</td>
<td>Personal care; per 15 minutes</td>
<td>Yes</td>
<td>Subject to expenditure cap.</td>
</tr>
<tr>
<td>Family Caregiver Stipend in lieu of SHC</td>
<td>T1020 U1 T1020 U2</td>
<td>570</td>
<td>Unit shall be used to bill/reimburse on a monthly basis. U1 modifier signifies children under 18 years old. U2 modifier signifies 18+. Amount of stipend paid will be determined during the planning process and is based on number of hours that services are needed.</td>
<td>No</td>
<td>U1 = $500/mo U2 = $1000/mo</td>
</tr>
<tr>
<td>Family to Family Support</td>
<td>T2025 SZ</td>
<td>969</td>
<td></td>
<td>No</td>
<td>TBD</td>
</tr>
<tr>
<td>Community Support Development, Organization and Navigation</td>
<td>T2025 U5 UA</td>
<td>969</td>
<td>Authorized as a monthly unit.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Family Caregiver Education and Training</td>
<td>T2012 UA</td>
<td>969</td>
<td>Units to be billed per pre-authorized occurrence of expense.</td>
<td>No</td>
<td>$500/year</td>
</tr>
<tr>
<td>Conservatorship and alternatives to Conservatorship counseling and assistance</td>
<td>T2025 U1 SE T2025 U2 SE T2025 U3 SE</td>
<td>969</td>
<td>T2025 U1 SE = Information/education session – individual face to face, not group setting). Must complete this one before can utilize lawyer or court fees. T2025 U2 SE = Lawyer fees T2025 U3 SE = Court fees</td>
<td>No</td>
<td>$500/lifetime; information/education session required in order to access other service components</td>
</tr>
<tr>
<td>Health insurance counseling/forms assistance</td>
<td>T2025 SE</td>
<td>969</td>
<td></td>
<td>No</td>
<td>15 hours/year</td>
</tr>
<tr>
<td>Intensive Behavioral Family Centered Treatment, Stabilization and Supports (IBFTSS)</td>
<td>H2020 HI/HN Refer to authorization</td>
<td>969</td>
<td>H2020. HI.HN Therapeutic behavioral services, per diem. Integrated mental health and intellectual disability/developmental disabilities program. Bachelor’s degree level)</td>
<td>No</td>
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### Benefits

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<tr>
<th>Benefits</th>
<th>HCPCS/ Modifier</th>
<th>Revenue Code</th>
<th>Description</th>
<th>Consumer Direction</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Behavioral Community Transition and Stabilization Services (IBCTSS)</td>
<td>H0018 HI U1 H0018 HI U2 H0019 HI</td>
<td>969</td>
<td>H0018- Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem. H0019 - Behavioral health; long-term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.</td>
<td>No</td>
<td>90 days per calendar year</td>
</tr>
<tr>
<td>IBFCTSS Outcome-Based Transition Planning and Implementation</td>
<td>T2038 HI U4 UA T2038 HI U4 UB T2038 HI U5 UA T2038 HI U5 UB T2038 HI U6 UA T2038 HI U6 UB</td>
<td>969</td>
<td>Outcome-Based Transition Planning and Implementation Incentive payment for successful and complete transition of person to promote stabilization and tenure from IBFCTSS to another ECF CHOICES plan (CH4A, CH5A, CH6A). Incentive is payable in 2 phases (2 months and 6 months following transition) dependent on the number of months the recipient has been enrolled in IBFCTSS.</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>IBFCTSS Outcome-Based Transition Planning and Implementation</td>
<td>T2038-HI U1 UA T2038-HI U1 UB T2038-HI U2 UA T2038-HI U2 UB T2038-HI U3 UA T2038-HI U3 UB</td>
<td>969</td>
<td>Outcome-Based Transition Planning and Implementation Incentive payment for successful and complete transition of person to promote stabilization and tenure from IBCTSS to another ECF CHOICES plan (CH4A, CH5A, CH6A). Incentive is payable in 2 phases (2 months and 6 months following transition) dependent on the number of months the recipient has been enrolled in IBFCTSS.</td>
<td>No</td>
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</table>

In addition to the benefits specified above, a person enrolled in ECF CHOICES may receive short-term nursing facility care as Medically Necessary for up to ninety (90) days. A person enrolled in ECF CHOICES receiving short-term nursing facility care will not be required to disenroll from their ECF CHOICES group until such time that it is determined that transition back to HCBS in ECF CHOICES will not occur within ninety (90) days from admission.

When billing for services rendered to ECF CHOICES Members, Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS1500 professional and CMS 1450 facility health insurance claim forms and/or the appropriate electronic filing format. In addition to the following ECF CHOICES-specific billing guidelines outlined below, all BlueCare/TennCare Select billing guidelines apply (see Section V. Billing and Reimbursement, of this Manual).

The reimbursement rates and codes for ECF CHOICES are based on methodology established by the Division of TennCare and will be updated according to the direction and at the discretion of the Division of TennCare. Only those HCPCS (CPT® and HCPCS Level II) codes on the fee schedule will be considered for reimbursement when filed in conjunction with the corresponding Revenue Code(s) and modifiers listed in the table below, otherwise charges will be denied for billing guidelines. **Services billed outside of the agreement are subject to recovery.** All services require prior authorization.

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Providers must comply with the Affordable Care Act and TennCare policy and procedures, including but not limited to, reporting overpayments, the requirement to report Provider-initiated refunds of overpayments to BlueCare Tennessee and TennCare Office of Program Integrity (OPI) and, when it is applicable, return overpayments to BlueCare Tennessee within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may be a violation of state or federal law.

**Note: Provider Preventable Conditions**

No payment shall be made by BlueCare Tennessee ECF CHOICES to a Provider for Provider-preventable conditions as defined in 42 CFR § 434.6(a) (12) and §447.26. BlueCare Tennessee ECF CHOICES requires Providers to identify Provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.


Refer to General Billing information (Section V. Billing and Reimbursement) of this Manual for Home Health Agency and Private Duty Nursing billing guidelines.

Refer to Utilization Management Guidelines (Section VIII. Utilization Management Program) of this Manual for Member benefits limitations and authorization guidelines.

**Electronic Billing Instruction**

Facilities wishing to submit claims electronically can contact the BCBST eBusiness Solutions Department at:

- Phone: 423-535-5717
- Fax: 423-535-7523
- E-mail: ecomm_support@bcbst.com
IX. Member Grievances and Appeals

Grievances

When Members and their caregivers have problems or grievances about care or a service Provider, they should report this to the Support Coordinator at 1-888-747-8955. If the Support Coordinator cannot resolve the problem, or if the grievance is about the Support Coordinator, grievances should be escalated to the BlueCare Tennessee Support Coordinator’s Supervisor or the ECF CHOICES Consumer Advocate. If BlueCare Tennessee is unable to resolve the problem or grievance, they may be escalated to the TennCare Solutions Unit, 1-800-878-3192.

Upon receiving a formal Member grievance, BlueCare Tennessee must respond to the complainant in writing within five (5) business days of receipt of the grievance. If the grievance can be resolved within the 5-day time period, the letter will include the resolution and basis for the resolution. If the grievance cannot be resolved, we will send a written notice to the grievant acknowledging receipt of the grievance.

The unresolved grievance will be reviewed, and a written follow-up response will be given to the grievant within thirty (30) calendar days. If the grievance involves abuse, neglect, or mistreatment, BlueCare Tennessee must notify the Division of TennCare at 1-877-224-0219 and, if appropriate, Department of Human Services/Adult Protective Services at 1-888-277-8366 in accordance with T.C.A. 71-6-103(b). Member grievances are documented in the CHOICES System of Record.

Appeals

An explanation of appeal rights is given to a Member upon enrollment in the ECF CHOICES program. When a service is denied, terminated, suspended, reduced, or delayed, the Member must be notified in writing by BlueCare Tennessee stating the reasons for the adverse action taken and include instructions how a Member can file an appeal and have a fair hearing. Providers of ECF CHOICES Members should also assist Members in the appeal process.

Members must be advised that if they file an appeal, they have the right to:

- have an attorney or someone else of their choice to speak for them;
- review information about why the service was denied, reduced, suspended, terminated, or delayed;
- present their evidence;
- ask questions of witnesses who are testifying during a hearing;
- ask for another medical opinion;
- have their services continued if they file an appeal within twenty (20) calendar days; and
- receive a written decision about the outcome of the appeal.

To appeal, a Member must respond within thirty (30) calendar days of the date he/she receives a letter informing him/her that a service has been denied, terminated, suspended, reduced, or delayed. An appeal form can be obtained from the TennCare Solutions Unit. If desired, an appeal can be submitted in any format. See Section VII. Member Policy of this Manual for detailed Member appeal instructions. Members can submit an appeal by mail, fax or phone.

Mail to: TennCare Solutions Unit
P O Box 00593
Nashville, TN 37202-0593

Fax to: 1-888-345-5575

Call: 1-800-878-3192

Members may request help with their appeal if they have a health, learning, or language problem by asking for the assistance of the BlueCare Tennessee ECF CHOICES Consumer Advocate, or by calling:

Tennessee Commission on Aging and Disability 1-877-236-0013
TennCare Solutions Unit 1-800-878-3192
Members having a hearing or speech problem and have a TTY/TDD machine, can call 1-800-772-7647 (TTY/TDD ONLY).

**Non-Discrimination Reporting of ECF CHOICES Events**

The following ECF CHOICES reportable event types must also be reported to BlueCare Tennessee:

- Allegations of disrespectful or inappropriate communication e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts that do not meet the definition of emotional or psychological abuse but which are directed to or within eyesight or audible range of the person supported.

- Any instance of disrespectful or inappropriate communication, e.g. humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse.

These events can be submitted by mail or phone:

**Mail to:** BlueCare/TennCare Select Non-Discrimination Compliance Coordinator  
1 Cameron Hill Circle  
Chattanooga, Tennessee 37402

**Call:** 1-800-276-1978 for TennCare Select Members  
1-800-468-9736 for BlueCare Members
X. Provider Appeal Process

See Section XII. Highlights of Provider/Subcontractor Agreement in this Manual for information on Provider payment disputes and independent reviews.
XI. General Information

A. Criminal Background Checks and Registry Checks

Criminal background checks and registry must be conducted and evaluated by the Provider on its employees, subcontractors, volunteers and agents, prior to providing services, in accordance with state law and TennCare policy. Additionally, criminal background checks and registry checks must be performed on any person who will have direct contact with a person receiving services in ECF CHOICES. At a minimum, criminal background checks, including registry checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and List of Excluded Individuals/Entities (LEIE). If a potential employee or volunteer's name appears on any of the preceding registries, that individual is disqualified from providing services to a CHOICES or ECF CHOICES person. If a potential employee or volunteer's criminal background check returns results, the Provider must use its discretion as to whether that individual is appropriate to have direct contact with persons. If a potential employee's criminal background check returns results, the Provider must provide the potential employee with an individualized assessment. This individualized assessment must take into account the following three (3) factors:

1. Whether or not the evidence gathered during the individualized assessment shows that the criminal conduct is related to the job in such a way that could place the Member at-risk;
2. The nature and gravity of the offense or conduct, such as whether the offense is related to physical or sexual or emotional abuse of another person, if the offense involves violence against another person or the manufacture, sale or distribution of drugs; and
3. The time that has passed since the offense or conduct and/or completion of the sentence.

Employees and volunteers who will not have direct contact with persons, but will have incidental contact only, must have registry checks for all registries listed above, but do not require criminal background checks. Appearance on any registry disqualifies an individual from having incidental contact with a person. Such registry checks must be performed prior to any employee or volunteer having any incidental contact with the person. For all volunteers and employees who qualify to provide services constituting only incidental contact with persons, the CHOICES or ECF CHOICES provider shall maintain proof that requisite registry checks were completed for MCO review during credentialing and re-credentialing visits, as requested.

The FEA shall be responsible for conducting criminal background checks and registry checks on its staff, its subcontractors, and consumer-directed workers. Additionally, all direct support employees hired after 1/1/17 must have all required criminal background checks and registry checks completed prior to serving any ECF CHOICES Member. Proof of these criminal background checks and registry checks must be identified during initial and recredentialing site visits and documented in all new hire files. Providers that are non-compliant will be subject to corrective action and/or disqualification from the contracting process.

B. Event Reporting

ECF CHOICES Providers are required to comply with the below processes for event reporting. All direct support staff working directly with people in ECF CHOICES shall complete required training on event reporting within thirty (30) days of hire and prior to providing direct support to Members.

Event Reporting is an important component of an overall approach for assuring the health, safety and welfare of individuals participating in home and community based services (HCBS). Event reporting in
ECF CHOICES has been designed in partnership with TennCare, the Department of Intellectual and Developmental Disabilities (DIDD), BlueCare and with input from HCBS Providers.

Reportable events are defined as events that:

- Occur during the delivery of covered Home and Community-Based Services (HCBS); and/or
- Are discovered or witnessed by BlueCare, Providers or Fiscal Employer Agent (FEA) staff regardless of whether the Provider or other HCBS factors are believed to have contributed to the incident.

The overall event reporting approach must also assure that persons supported (and involved family or other unpaid caregivers, as appropriate) are informed about their rights and protections, including how they can safely report any event they believe compromises the health, safety, individual freedom or quality of life of an ECF CHOICES Member.

BlueCare Tennessee will implement the current collaborative approach used with contracted Providers in the CHOICES program to make sure that important information sharing is occurring between ECF CHOICES Providers and BlueCare and that BlueCare is taking the lead in working with Providers to help ensure that appropriate services and supports are being provided to ECF CHOICES Members.

For ECF CHOICES, there are three tiers of reportable events. The type of reportable event dictates the reporting requirements and process that must be followed by the provider, BlueCare and DIDD (if applicable).

**Tier 1 Reportable Events** shall include the following:

- Allegations or suspicion of abuse (physical, sexual, and emotional/physiological), neglect, or exploitation resulting in physical harm, pain or mental anguish;
  - Abuse, Neglect, and Exploitation shall be defined as in TCA 33-2-402 and implemented as specified in TennCare protocol.
  - Sexual Abuse includes sexual battery by an authority figure as defined in TCA 39-13-527.
- All unexpected or unexplained deaths, including suicide;
- Serious injury, including serious injury of unknown cause;
  - Serious injury is any injury requiring medical treatment beyond first aid by a layperson, and includes, but is not limited to: fractures, dislocations, concussions, cuts or lacerations requiring sutures, staples, or dermabond; torn ligaments (e.g., a severe sprain) or torn muscles or tendons (e.g., a severe strain) requiring surgical repair, second and third degree burns, and loss of consciousness.
- Suspicious injury where abuse or neglect is suspected or the nature of the injury does not coincide with explanation of how injury was sustained);
- Vehicle accident while transporting person resulting in injury or a moving violation with significant risk of harm (e.g., reckless driving or driving under the influence);
- Medication error resulting in the need for face-to-face medical treatment based on injury or probable risk of serious harm, including Physician services, emergency assistance or transfer to an acute care facility for stabilization. Such errors include: administration of the wrong drug or wrong dose; medication omission; administration to the wrong person, at the wrong time, at the wrong rate; or administration involving wrong preparation or wrong route of administration;
- Theft of more than $1000 (Class E felony).

**Tier 1 Reportable Events Reporting Requirements:**

- All Tier 1 reportable events must be reported to DIDD verbally within four (4) hours of witnessing or discovery of the Tier 1 reportable event. Report to DIDD using appropriate hotline number in the corresponding region.
The ECF CHOICES Provider must submit a corresponding written, preferably typed Reportable Event Form (REF) to DIDD by close of the next business day counting from the date of verbal notification. The ECF CHOICES Provider and BlueCare will not move forward with their own “reviews” if a Tier 1 Reportable Event has been reported.

All Tier 1 reportable events will be reported to TennCare by DIDD within 24 hours of receipt of ECF Reportable Event Form.

DIDD is responsible for investigating all Tier 1 reportable events.

DIDD will communicate with the Provider to obtain any additional information needed to support verification that the reportable event is appropriately classified as Tier 1.

- If DIDD determines that the reportable event is not a Tier 1:
  - DIDD will amend the Reportable Event Form and send to the Provider and BlueCare by close of the next business day; and
  - DIDD will send any supporting documentation to BlueCare by the close of the next business day.

ECF CHOICES Providers are required to submit the reportable events to BlueCare utilizing the ECF Reportable Event Form located at [http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html](http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html) via e-mail to ECFREF@bcbst.com, or via fax (only if e-mail is not available) to 1-855-472-0156, and/or to DIDD via e-mail to ECF.REF@tn.gov, or via fax (only if e-mail is not available) to 1-877-551-5591.

ECF CHOICES Providers must immediately take steps to prevent further harm to any and all Members and respond to any emergency needs of Members. If the allegation concerns a Tier 1 Reportable Event allegation of physical or sexual abuse relating to an ECF CHOICES worker, BlueCare shall ensure that the Provider either places the worker on administrative leave or in another position in which he or she does not have direct contact with, or supervisory responsibility for, a person supported until DIDD has completed its investigation. Providers may request an exception to this administrative leave policy in a method prescribed by TennCare. Providers may additionally decide to remove staff concerning other Tier 1 and Tier 2 Reportable Events at their discretion and pursuant to agency policy.

**Tier 2 Reportable Events** shall include the following:

- A Member whose whereabouts are unknown and which likely place the Member in a dangerous situation for himself/herself or others. This is reportable as a Tier 2 reportable event if the whereabouts of the Member are unknown for sixty (60) minutes or more if the absence is unusual, unless a shorter time is specified in the person’s PCSP or Behavior Support Plan (BSP), or the absence is a known risk as specified in the person’s PCSP or the BSP. Reporting that a Member’s whereabouts are unknown is in addition to, and not a substitute for, actively looking for the Member and contacting law enforcement if necessary.
  - Persons supported shall have the freedom to come and go without staff supervision, except when such restrictions are necessary to ensure their health and safety or the safety of others, which must be documented in the PCSP.
- Minor vehicle accident not resulting in injury;
- Victim of fire;
- Medication variance resulting in the need for observation, which may include the need to seek practitioner care or advice, but does not require face-to-face treatment as there is no injury or identified and probable risk of serious harm including Physician services, emergency assistance, or transfer to an acute inpatient facility for stabilization. Such variances include administration of the wrong drug or wrong dose; medication omission administration to the wrong person, at the wrong time, at the wrong rate; or administration involving wrong preparation or wrong route of administration;
- Unsafe environment (uncleanliness/ or hazardous conditions);
- The use of manual or mechanical restraint or protective equipment approved for use in the person’s initial PCSP or BSP, but used incorrectly or in a manner other than intended. Reportable Events determined to be outside of an approved PCSP or BSP or intentionally inappropriate or in violation of guidelines specified in the person’s PCSP or BSP shall be referred to DIDD as a Tier 1 Reportable Event.
• Allegations of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts that do not meet the definition of emotional or psychological abuse but which are directed to or within eyesight or audible range of the person supported. (Please note that these event types must also be reported to BlueCare Tennessee’s Non-Discrimination Compliance Coordinator in writing at 1 Cameron Hill Circle, Chattanooga, Tennessee 37402 or via telephone at 1-800-276-1978 for TennCare Select Members or 1-800-468-9736 for BlueCare Members.)

• The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of belongings or money valued at $1,000 or less, i.e., less than the threshold for misappropriation.

Tier 2 Reportable Events Reporting Requirements:
• The ECF CHOICES Provider must submit an initial notification of a Tier 2 reportable event to both BlueCare and DIDD using the Reportable Event Form via data exchange by close of the next business day counting from the date of witnessing or discovery of the reportable event.

• BlueCare will be responsible for reviewing all Tier 2 Reportable Event Forms for completeness and for ensuring the Reportable Event has been appropriately identified as Tier 2. BlueCare will provide written notification to the ECF CHOICES provider confirming the Tier 2 status of the Event. If BlueCare determines that the Reportable Event needs to be reclassified, BlueCare will amend the Reportable Event Form and follow the other appropriate requirements for the reclassified Reportable Event, as stated herein.

Process for Investigation of Tier Two Reportable Events (including referral)
• ECF CHOICES Providers are responsible for conducting investigations of Tier 2 Reportable Events and submitting an investigation report for each Tier 2 Reportable Event to BlueCare.

• An ECF CHOICES Provider shall complete the investigation and submit to BlueCare a completed investigation report within fourteen (14) calendar days of the anchor date.
  - BlueCare may at its discretion grant one (1) seven (7)-day extension to the Provider. Such extension processes shall not apply for reportable event investigations in consumer direction in which BlueCare, and not the Provider is responsible for investigating.

• BlueCare is responsible for reviewing Tier 2 Reportable Event investigation reports submitted by the ECF CHOICES Provider and for any follow-up review determined to be needed.

• BlueCare shall have thirty (30) Calendar days from the anchor date to review the Provider’s investigation report and make one of the following determinations which must be sent to the Provider in writing:
  - If additional information from the Provider is necessary to complete the review, BlueCare shall notify the Provider in writing and shall have fourteen (14) Calendar days from the date of such notification to complete a review of the Provider’s investigation and determine whether to accept or make findings on the report and notify the Provider.

• If at any time during the Tier 2 Reportable Event review, the information obtained by BlueCare supports a Tier 1 (rather than Tier 2) reportable event:
  - BlueCare will notify DIDD within four (4) hours by phone following discovery that a Tier 2 reportable event should be classified as Tier 1 (Notification should be made to DIDD by a phone call to the appropriate hotline number in the corresponding region).
  - BlueCare will submit an amended ECF Reportable Event form to DIDD and the Provider for the reportable event by the close of next business day counting from the day of discovery of the incorrectly classified reportable event.

Tier 2 Reportable Events: Policy on Administrative Leave or Non-Direct Contact
• ECF CHOICES Providers shall determine, at their discretion and in accordance with their agency’s policy, whether to remove an employee or volunteer named in a Tier 2 Reportable Event from any or all direct support to CHOICES and ECF CHOICES Members until the Provider has completed their investigation and, if the Reportable Event is determined to be a reportable event, until the completion of any corrective action (e.g., training) deemed appropriate. In lieu of removing an employee or
volunteer named in a Tier 2 Reportable Event from any or all direct support to CHOICES and ECF CHOICES Members, the Provider may opt to utilize a modified assignment or increased supervision. The Provider is expected to ensure that adequate steps are taken for the protection and safety of all CHOICES and ECF CHOICES Members during the investigation process.

- ECF CHOICES Providers are required to submit the Tier 2 reportable events to BlueCare utilizing the ECF Reportable Event Form located at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html. The ECF Reportable Event Form must be submitted to BlueCare via e-mail to ECFREF@bcbst.com, or via fax (only if e-mail is not available) to 1-855-472-0156.
  - The ECF Reportable Event Form must be submitted to DIDD via e-mail to ECF.REF@tn.gov, or via fax (only if e-mail is not available) to 1-877-551-5591.
  - ECF CHOICES Providers are required to submit any Tier 2 investigation findings utilizing the ECF Tier 2 Reportable Event Provider Investigation Report Form located at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html via e-mail to ECFREF@bcbst.com, or via fax (only if e-mail is not available) to 1-855-472-0156.

**Tier 3 Reportable Medical and Behavioral Events**

**Tier 3 Reportable Medical Events shall include the following:**
- Deaths (other than those that are unexpected/unexplained);
- ER visits;
- Any inpatient observation or admission (acute care, LTAC, or SNF/NF);
- Use of CPR or an automated external defibrillator (AED);
- Choking episode requiring physical intervention (e.g., use of abdominal thrust or Heimlich maneuver);
- Fall with injury (including minor or serious);
- Insect or animal bite requiring treatment by a medical professional;
- Stage II and above pressure ulcer;
- Staph infection;
- Fecal impaction;
- Severe dehydration requiring medical attention;
- Seizure progressing to status epilepticus;
- Pneumonia;
- Severe allergic reaction requiring medical attention; and
- Victim of natural disaster (natural disasters affecting multiple individuals do not require multiple individual reports).

**Tier 3 Reportable Behavioral Events shall include the following:**
- Criminal conduct or incarceration;
- Engagement of law enforcement;
- Sexual aggression;
- Physical aggression;
- Injury to another person as a result of a behavioral incident of a person supported;
- Suicide attempt;
- Self-injurious behavior;
- Property destruction greater than $100;
- Swallow inedible/harmful matter;
- Behavioral crisis requiring protective equipment, manual or mechanical restraints, regardless of type or time used or approved by PCSP (all take-downs and prone restraints are prohibited);
- Behavioral crisis requiring PRN psychotropic medication;

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Behavioral crisis requiring crisis intervention (i.e., call);
Behavioral crisis requiring in-home stabilization (SOS participants only);
Behavioral crisis requiring out-of-home therapeutic respite; and
Psychiatric admission (or observation), including in acute care hospital
Tier 3 Reportable Medical and Behavioral Events are only reported to BlueCare (not to DIDD) on the Reportable Event Form.
ECF CHOICES Providers must submit a written ECF Tier 3 Reportable Event Form to BlueCare within two (2) business days of witnessing or discovery of the Tier 3 reportable event.
Reporting and review of such Tier 3 reportable events is secondary to any medical attention required by the person supported.
The Provider's supervisory staff (including clinical staff, as applicable) is required to review the Event in order to determine appropriate follow-up, which may include:
- Follow up with the person's primary care Provider (or behavioral health Provider, as applicable) to provide information and determine any needed treatment adjustments
- Follow up with the person's Support Coordinator regarding any needed adjustments in the PCSP; and
- Targeted training or assistance for agency staff who support the person.
All Tier 3 reportable events, any medical attention provided, and follow-up shall be documented in the person's record.
Both the Provider and BlueCare shall be responsible for tracking and trending all Tier 3 Reportable Events above and evaluating such events to determine how to prevent or reduce similar occurrences in the future whenever possible.
Such efforts may be targeted to an individual person supported, a particular service setting or location, a particular type of Tier 3 Reportable Event, a particular Provider, or may be system-wide.
ECF CHOICES Providers are required to submit Tier 3 Reportable medical and behavioral events to BlueCare utilizing the ECF Reportable Event Form located at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html via e-mail to ECFREF@bcbst.com, or via fax (only if e-mail is not available) to 1-855-472-0156.

Non-Reportable Events and Requirements
Non-Reportable Events are events which the ECF Provider is not required to report to BlueCare or DIDD, but which the Provider is responsible for documenting, addressing, tracking and trending in order to prevent similar occurrences in the future whenever possible.

Non-reportable events shall include circumstances that are not reportable events as defined herein. Non-reportable events include the following when related to a person supported by ECF CHOICES services:
- Any instance of disrespectful or inappropriate communication, e.g., humiliation, harassment, threats of punishment or deprivation, intimidation or demeaning or derogatory communication (vocal, written, gestures) or any other acts pertaining to a person supported that is not directed to or within eyesight or audible range of the person supported and that does not meet the definition of emotional or psychological abuse. (Please note that these event types must also be reported to BlueCare Tennessee’s Non-Discrimination Compliance Coordinator in writing at 1 Cameron Hill Circle, Chattanooga, Tennessee 37402 or via telephone at 800-276-1978 for TennCare Select Members or 800-468-9736 for BlueCare Members.)
- Failure to provide goods or services when such failure do not result in injury or probable risk of serious harm (i.e., does not meet neglect threshold);
- Minor injury not requiring medical treatment beyond first aid by a lay person and is not associated with abuse or neglect; and
- Staff misconduct that falls outside the definition of Tier 1 or Tier 2 reportable events or Tier 3 Reportable Medical and Behavioral Events and does not result in serious injury or probable risk of serious injury. An example would include failure to follow the PCSP when such action (or inaction)
would not pose a probable risk of serious injury; staff convenience or minor traffic violation while transporting person.

- ECF CHOICES Providers are expected to document, review, address and track and trend Non-Reportable Events because of the potential to positively impact quality of care and health and safety for all Members served by that Provider. Each Provider’s Non-Reportable Events and its internal tracking and trending efforts shall be reviewed as part of ongoing quality monitoring efforts by BlueCare and the DIDD.

- ECF CHOICES Providers are not required to report Non-Reportable Events to any external entity except in instances when the Provider conducts its review and determines that the Event is a Reportable Event.
  - If it is determined to be a Tier 1 Reportable Event, the Provider will immediately notify DIDD by a phone call to the appropriate hotline number in the corresponding region, and submit an ECF Reportable Event Form (REF) via data exchange by the close of the next business day.
  - If it is determined to be a Tier 2 Reportable Event, the Provider will notify BlueCare and DIDD by the close of the next business day.
  - If it is determined to be a Tier 3 Reportable (Medical or Behavioral) Event, the Provider will notify BlueCare within two (2) business days.

- All subsequent processes, including investigation, review, etc. shall proceed as outlined herein.

Tracking and Trending Reportable Events (Including Reportable Events that are determined to be Critical Incidents) and Non-Reportable Events

- Tracking and trending efforts by Providers, BlueCare and DIDD shall include determining which Reportable Events are Critical Incidents. A Reportable Event is classified as a Critical Incident when there is a determination that the ECF CHOICES Provider and/or BlueCare could have and should have done something differently in order to prevent the reportable event or reduce the negative consequences of that incident on the Member and others involved.

- For reportable event, it is especially vital to evaluate the nature, frequency and circumstances of these events in order to determine how to prevent or reduce similar occurrences in the future, whenever possible. Such efforts may be targeted to an individual person supported, a particular service setting or location, a particular type of reportable event, and including for BlueCare, a particular Provider, or system-wide.

- DIDD will maintain a statewide system for tracking and trending data for all Tier 1 and Tier 2 Reportable Events, including those Events classified as Critical Incidents.
  - Trending may include the following views: system-wide, by program (HCBS waiver or ECF CHOICES), by Provider type, by Provider, by type of event and/or incident, by individual, or any other perspective determined to be beneficial for purposes of evaluation, remediation and system improvement.
  - All Tier 1 and Tier 2 Reportable Event and Critical Incident data shall be tracked and trended by DIDD on at least a quarterly basis.

- Both the Provider and BlueCare shall be responsible for tracking and trending all Tier 3 Reportable Events, including those Events classified as Critical Incidents.

- All Tier 1, Tier 2 and Tier 3 Reportable Events and Critical Incidents shall be tracked and trended by BlueCare on at least a quarterly basis.

- All Tier 1, Tier 2, Tier 3 Reportable Event (including those classified as Critical Incidents), and Non-Reportable Events shall be tracked and trended by the ECF CHOICES Provider on at least a quarterly basis.

- Trending will include summation of the nature, frequency, and circumstances of the Events and Incidents being tracked.

- BlueCare, in collaboration with their Providers, will evaluate the trended data and with regard to trended data for Critical Incidents in particular, will evaluate this data in order to determine how to prevent or reduce similar occurrences in the future.
Allegations of both direct (Tier 2) and non-direct (Non-Reportable) disrespectful or inappropriate communication shall be reported to BlueCare by Providers to be included on BlueCare’s non-discrimination report.

FEA Responsibilities

- FEA and Provider staff must immediately report, after the occurrence or discovery of occurrence, all instances of suspected abuse, neglect, and exploitation of members who are adults in accordance with TCA 71-6-103 and suspected brutality, abuse, or neglect of Members who are children in accordance with TCA 37-1-403 or TCA 37-1-605 as applicable.
- All Tier 1 and Tier 2 Reportable Events occurring during the provision of ECF CHOICES services or discovered or witnessed by a Fiscal Employer Agent (FEA) employee must be reported to the DIDD and BlueCare via data exchange and copied to the Employer of Record within the required timeframe.

Reportable Events Reported by Member or a Member’s Natural Supports

- All Tier 1 or Tier 2 Reportable Events reported to the DIDD or BlueCare by: 1) Member 2) Caregiver, 3) Family member, or 4) Citizen/Friend and having occurred during the provision of ECF CHOICES services will be documented by DIDD or BlueCare, as applicable.
- DIDD or BlueCare receiving the report will generate, within one (1) business day, an ECF Reportable Event Form, if the reported occurrence is confirmed to be Tier 1 or Tier 2 Reportable Event.
- The entity receiving the report from the Member or the Member’s natural support (either DIDD or BlueCare) will be responsible for submitting the completed ECF Reportable Event Form to the other entity.
- The Provider’s Incident Management Coordinator or designee will be notified, via data exchange, of the Reportable Event by close of the next business day after the DIDD or BlueCare received the report from the Member or the Member’s natural support.
- DIDD, BlueCare and the Provider will follow the process for investigations based on the Tier that the Reportable Event falls into.

C. Quality Monitoring

The Tennessee Department of Intellectual and Developmental Disabilities (DIDD) conducts quality monitoring of ECF CHOICES services. Upon initiation of services by an ECF CHOICES Provider, BlueCare will notify DIDD for purposes of scheduling consultative and/or annual quality monitoring surveys, as applicable. The reviews typically take place on site at the Provider’s agency, and include a comprehensive look at the Provider’s policies and practices (including interviews with staff members). The results of the review will be provided to the MCOs, who will assess the results and work with Providers to recognize best practices and to continuously improve quality. Quality and compliance are handled differently. Ensuring that ECF Providers contracted to serve ECF Members, BlueCare will validate compliance prior to approving contract. This process is handled through the credentialing and re-credentialing process. In the ECF program, one of the goals of the quality process is to aid in identifying Providers that display quality performance above compliance. Following each consultative and annual survey involving BlueCare Members, BlueCare and DIDD will meet to discuss the survey results and findings prior to presenting the results and findings to the Provider surveyed. BlueCare will ensure that a Provider Relations Consultant is present during the exit interview at the conclusion of the quality onsite review.

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<tr>
<th>Employment and Community First CHOICES service</th>
<th>Quality monitoring entity</th>
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<tr>
<td>Employment services (excluding benefits counseling)</td>
<td>DIDD</td>
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<tr>
<td>Community-integrated support services</td>
<td>DIDD</td>
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The domains that will be audited are noted below:

- Access and Orientation for Services
- Person-Centered Support Plan Implementation and Support Delivery
- Choice and Decision-Making
- Opportunities for Integrated Work
- Relationships and Community Membership
- Rights, Respect, Dignity
- Health
- Safety and Security
- Direct Support Staff

Expected outcomes are defined under each domain and results are based upon performance accordance to the indicators. BlueCare provider relations, support coordinators, or medical directors could be involved and sought for feedback.

Based on final survey results for consultative and annual surveys conducted by DIDD, Blue Care may institute the following:

- Onsite monitoring pending resolution of immediate jeopardy situations;
- Corrective action plans;
- A moratorium on new referrals; or
- Transition ECF CHOICES Members to another Provider and termination of the Provider agreement.
D. Neglect and Abuse Information

While providing services, Providers are required to assess a Member for neglect and/or abuse or the potential for abuse and/or neglect. Whenever possible, steps should be taken to reduce a Member’s risk of abuse and/or neglect by collaborating with the Support Coordinator to address potential risks (e.g., frequency of Support Coordinator home visits, referrals to non-covered support services).

Indicators of suspected abuse and/or neglect are:

**General**
Signs and symptoms of abuse and neglect may include physical indicators such as injuries or bruises. There also may be behavioral clues, including how victims and abusers act or interact with one another. Many of the indicators listed below can be explained by other causes (e.g., a bruise may be the result of an accidental fall) and no single indicator can be taken as conclusive proof. However, their presence will be grounds for considering whether a case of suspected abuse or neglect should be reported to the appropriate state agency.

Support Coordinators, subcontractors, Providers and other staff having contact with Members will be educated as part of their training to look for patterns or clusters of indicators that suggest problems warranting closer investigation.

Specific signs and symptoms are provided below, by type of abuse and neglect.

**Physical Abuse**
- Sprains, dislocations, fractures or broken bones;
- Burns from cigarettes, appliances or hot water;
- Abrasions on arms, legs or torso that resemble rope or strap marks;
- Cuts, lacerations or puncture wounds;
- Fractures of long bones and ribs;
- Internal injuries evidenced by pain, difficulty with normal functioning of organs, and bleeding from body orifices;
- Bruises, welts or discolorations of the following types:
  - Bilateral, or "matching" bruises on both arms that may indicate the Member has been shaken, grabbed or restrained
  - Bilateral bruising of the inner thighs that may indicate sexual abuse
  - "Wrap around" bruises encircling the Member’s arms, legs or torso that may indicate the individual has been physically restrained
  - Clustered bruising on the trunk or another area of the body
  - Bruising in the shape of an object that may have been used to inflict injury
  - Multicolored bruises that may indicate the person has sustained multiple traumas over time, i.e., presence of old and new bruises at the same time;
- Injuries healing through "secondary intention" (indicating that the Member did not receive appropriate treatment), including but not limited to:
  - Lack of bandages on injuries or stitched when indicated
  - Evidence of unset bones;
- Signs of traumatic hair loss, possibly with hemorrhaging below scalp;
- Signs of traumatic tooth loss;
- Injuries that are incompatible with the Member’s explanation;
- Inconsistent or conflicting information from family members about how injuries were sustained;
- A history of similar injuries and/or numerous or suspicious hospitalizations;
- A history of Member being brought to different medical facilities for treatment to prevent medical Practitioners from observing patterns;
- Delays between the onset of injury and seeking of medical care; and
Signs of confinement (e.g., Member is locked in his or her room).

Sexual Abuse
- Vaginal or anal pain, irritation or bleeding;
- Bruises on external genitalia, inner thighs, abdomen or pelvis;
- Difficulty walking or sitting not explained by other physical conditions;
- Stained or bloody underclothing;
- Sexually transmitted diseases;
- Urinary tract infections, particularly where patterns are observed;
- Inappropriate sex-role relationships between victims and suspects;
- Inappropriate, unusual or aggressive sexual behavior, particularly when it has been recently acquired; and
- Signs of psychological trauma including excessive sleep, depression or fearfulness.

Financial Exploitation
- Visitors ask the Member to sign documents the Member does not understand;
- Unpaid bills, despite adequate financial resources, when a caregiver or other party is expected to be paying the bills;
- Lack of affordable amenities for the Member, such as personal grooming items or appropriate clothing;
- New "best friends" who take an interest in the Member's finances;
- Legal documents, such as powers of attorney, which the Member did not understand at the time he/she signed them;
- Unusual activity in the Member's bank accounts including large, unexplained withdrawals, frequent transfers between accounts or other activity that the Member cannot explain;
- A caregiver expresses excessive interest in the amount of money being spent on the Member;
- Belongings or property are missing;
- Suspicious signatures on checks or other documents, including signatures not matching the Member's or signatures and other writing by a Member who cannot write;
- Absence of documentation about financial arrangements;
- Implausible explanations about the Member's finances are given by the Member or the caregiver; and
- The Member is unaware of or does not understand financial arrangements that have been made for him or her.

Emotional (Psychological) Abuse
- Berating, ignoring, ridiculing or cursing of a Member;
- Threats of punishment or deprivation;
- Significant weight loss or gain that cannot be attributed to other causes;
- Stress-related conditions including elevated blood pressure;
- The perpetrator isolates the Member emotionally by not speaking to, touching or comforting him/her;
- The Member is depressed, confused, withdrawn, emotionally upset or non-responsive; and
- The Member cowers in the presence of the suspected abuser or exhibits unusual behavior typically associated with dementia (e.g., sucking, biting, rocking) in the absence of a dementia diagnosis.

Neglect
- Weight loss that cannot be explained by other causes;
- Lack of toileting that causes incontinence, which results in Member sitting in urine and feces;
- Increased falls and agitation, indignity and skin breakdown;
- Pressure ulcers. Although certain types of pressure ulcers are common and difficult to avoid (e.g., where bony protuberances support body weight in Members who have peripheral vascular disease, diabetes, stroke and dementia), other ulcers cannot be readily excused. For example, ulcers on heels, ankles and knees suggest a Member has been left for long periods with inadequate padding or repositioning;
- Evidence of inadequate or inappropriate use of medication;
Personal hygiene is neglected;
- Lack of assistance with eating, drinking, walking, bathing, and participating in activities; and
- Requests for personal assistance are unheeded.

**Family/Caregiver Indicators**
- Family member/caregiver does not provide an opportunity for the Member to speak for him or herself or see others without the presence of the caregiver;
- Attitude of indifference or anger toward the Member;
- Family member/caregiver blames the Member for his or her condition (e.g., accusation that incontinence is a deliberate act); and
- Aggressive behavior toward the Member, including threats, insults or harassment.

Any suspicion of abuse and/or neglect should be reported, including suspected and/or neglect of a child pursuant to TCA 37-1-403, reporting suspected abuse and/or neglect of an adult to Adult Protective Services pursuant to TCA 71-6-103, and reporting suspected abuse and/or neglect to BlueCare Tennessee pursuant to Section 2.15.7.1.4. The Provider should coordinate and cooperate with Adult Protective Services/Child Protective Services investigations and remediation.

<table>
<thead>
<tr>
<th>Adult Protective Services</th>
<th>Child Protective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 1-888-277-8366</td>
<td>Phone 1-877-237-0004</td>
</tr>
<tr>
<td>Fax 1-866-294-3961</td>
<td></td>
</tr>
</tbody>
</table>

Necessary steps should be taken to protect the Member from further abuse (e.g., removing a staff person suspected of committing the abuse and/or neglect, making referrals for Members to support services).

**E. Coordination with other Managed Care Organizations (MCOs)**

For covered long-term services and supports for ECF CHOICES Members who are transferring from another MCO, the receiving MCO is responsible for continuing to provide covered long-term services and supports, including both ECF CHOICES HCBS authorized and nursing facility services, for a minimum of thirty (30) days without regard to whether such services are being provided by contract or non-contract Providers.

For a minimum of thirty (30) days after the Member’s enrollment and thereafter, the receiving MCO shall not reduce the Member’s services unless a support coordinator has conducted a comprehensive needs assessment and developed an initial support plan, and the receiving MCO has authorized and initiated ECF CHOICES HCBS in accordance with the Member’s initial support plan.

**F. BlueCare Provider Compliance Program**

Providers contracted with BlueCare must adhere to the EVV compliance program in accordance with established metrics and required standards. BlueCare monitors and audits identified measurable elements to ensure Providers maintain requirements of the compliance program. Any enforcement and disciplinary process for violations of the program will be conducted in accordance with the guidelines outlined.

Contracted Providers are responsible for all EVV record keeping, including any visit maintenance, prior to submitting a claim associated with the EVV record. Providers must ensure the highest quality of support to all members, through continuous and timely monitoring of services for assigned members with authorized services at all times. Providers are responsible for managing and monitoring their Direct Support Professionals (DSP) to ensure approved services are delivered as expected using mandated EVV
systems and tools. Immediate attention and action is required by Providers when a Provider is considered non-compliant. Failure to achieve and maintain compliance as outlined in the assessment of liquidated damages on violations that occurred during the review period, the imposition of contract actions (including contract termination) and/or the corrective action plan process.

Providers should utilize EVV reports to monitor their performance and ensure they are meeting the compliance requirement relative to visit verification and adherence to the compliance standards. The reports can be accessed through the EVV database. Providers should validate the accuracy of claims prior to submissions, in accordance to the authorization effective for the date of service on the claim. When paper time sheets reflect a difference in service times rendered compared to the applicable authorization on file, the schedule will be rejected. Providers must then make corrections to the schedule, and submit the claim to reflect the corrected schedule.

Newly contracted Providers that are preparing staff and operational requirements to become compliant to the EVV Compliance program will be allowed a grace period. The grace period should be used to train staff on the system, and ensure that the EVV Coordinators are aware of all performance visit maintenance tasks. The grace period is typically the first ninety days after receiving the Provider EVV database. Any grace periods required must be approved by BlueCare.

Provider EVV Compliance Standards

- Provider agencies must adhere to all requirements included in the compliance plan.
- Providers are expected to import all member referrals within 24 hours of notification.
- Providers will receive authorizations and copies of the member's Person Plan of Care (PCSP) indicative of services and service times. Upon receipt of the PCSP, providers are expected to complete the attestation process in the EVV database.
- Providers are expected to attach the assigned DSP to the member schedule within 24 hours of importing the new member.
- Providers must ensure all DSPs have been successfully trained on the GPS EVV tablet, EVV Telephony, and EVV Bring Your Own Device (BYOD). The DSP training record should be documented, including essential refresher and ongoing training when applicable (including how to review schedules, and logging in and out). Training records must include attestation by the DSP that is indicative of the employee's competency of EVV compliance and standards, including approved clock-in/out procedures.
- Providers are responsible for validating all DSPs are recording member visits (check in and check out) during the visit using the GPS tablet device, EVV Telephony, or EVV BYOD at all times. If the GPS tablet is not available, DSPs should use EVV Telephony or EVV BYOD as back-up methods.
- Adherence to completing all GPS tablet device assessments upon clocking out at the end of member visits or services is required.
- When a DSP identifies an issue with a GPS tablet device, the DSP must clock in using EVV Telephony or EVV BYOD and report the GPS issue to the provider immediately to prevent missed/late visits.
- When a DSP reports an issue with a GPS tablet device, the provider or responsible EVV Coordinator must contact BlueCare to report the issue within 24 hours of the visit to ensure interference with the quality of care provided to a member does not occur.
- Paper timesheets to document service delivery are only accepted with prior approval as the GPS Tablet Device, and EVV Telephony and EVV BYOD are the approved methods for clocking in and clocking out.
- Timely maintenance must be performed daily to clear exceptions; corrections must be completed within one week of the scheduled visit. Providers must ensure all visit maintenance is completed prior to submitting claims.
Any scheduled visit that is identified as missed/late or changed must have populated an acceptable reason code within one day of the missed/late visit.

When the reason code "Member refused service/Member refused Alternate Staff" is entered as a reason code, supporting comments identifying time, date, and person providing the information must be populated in the EVV data base. If the person providing the information is not the member, the comment must include the person’s name and relationship to the member.

Providers must receive prior approval from BlueCare when EVV visits require manual confirmation and need paper time sheets for invoicing.

When time sheets are permissible, the following guidelines must be followed and include the following evidence prior to approval for releasing units. Providers may use their own timesheet template to include all standard agency information; and must contain an attestation statement certifying the accuracy of the data that will be submitted.

- Timesheets should record two signatures; the DSP and member (or member’s authorized representative and their relationship to member).
- The signatures must be original; copied signatures will be rejected.
- The service and service date(s) must be accurately exhibited; timesheets submitted prior to service rendered dates will be rejected.
- Signatures must include the date that each signature was obtained.
- Any signature for which signature requirements are not met will be subject to advanced auditing, authentication, and possible Medicaid fraud referral.
- The reason(s) for paper timesheet submissions verses the approved, required use of the EVV system should be included to facilitate approval process.

**Provider EVV Compliance Monitoring**

Providers are expected to implement EVV Compliance procedures immediately. BlueCare will begin measuring compliance metrics effective March 1, 2018. For the first quarter 2018, BlueCare will look at the months of February and March only. Thresholds for those two months will be averaged to obtain Provider’s performance score for Q1. Q1 will be considered each Provider’s baseline and will be used to show the provider where areas of improvement are needed. The expected minimum compliance score for Q1 is 70% in each area measured, as detailed below. BlueCare will work with Providers to develop corrective action plans based on Q1 performance to assist the Provider in achieving compliance thresholds and improved performance. Compliance threshold expectations (scores) will increase each quarter throughout 2018, as detailed below.

**Performance Metrics measured for Provider compliance:**

*Electronic Visit Verification (EVV) Activity*

- Provider EVV activity is the number of visits that were provided on time per the Member’s needs and preferences and are captured in the EVV system per the Member’s schedule. Scores will be calculated as total on-time visits divided by the total visits scheduled

**Example:**

100 total visits
5 missed visits (weighs same)
5 late visits (weighs same)
90 on-time visits
90/100 = 90% compliance score

- Provider compliance with EVV activity will be monitored on an ongoing basis. The following minimum compliance scores are expected:
- Q1 – 70%
- Q2 – 80%
- Q3 – 90%
- Q4 – 90% or higher

- Providers that have not met the minimum performance requirements are subject to corrective actions, Member moratoriums, or possible liquidated damages. Possible liquidated damages will not be applied to Q1.

**EVV Confirmed Visits**

- Provider EVV confirmed visits are visits for which the Provider did not have to request and submit manual confirmations to BlueCare for approval. Manual confirmations are instances in which the Provider submits paper timesheets requesting approval of time submitted. Any visit that is confirmed without any use of EVV for clocking in or clocking out is considered non-compliant and manually confirmed. BlueCare will measure EVV confirmed visits as compliant.

  - Scores will be calculated as total manually confirmed visits divided by the total number of visits.

**Example:**

100 total missed visits  
5 missed/late visits w/o reason codes/comments  
95 missed visits with reason codes/comments  
95/100 = 95% compliance score

- Provider compliance with EVV database maintenance will be monitored on an ongoing basis. The following minimum compliance scores are expected:
  - Q1 – 70%
  - Q2 – 80%
  - Q3 – 90%
  - Q4 – 90% or higher

- When Provider records are identified to be non-compliant due to misuse of reason codes, the Provider may be subject to: liquidated damages, contract actions, correct action plan or Medicaid fraud referral.

- Providers that have not met the minimum performance requirements are subject to corrective actions, Member moratoriums, or possible liquidated damages. Possible liquidated damages will not be applied to Q1.

**Provider EVV Claims Compliance**

- All claims must be submitted within 120 days from the date of service or will be subject to denials. It is highly recommended that claims are submitted within seven days of the Member visits in support of properly maintained EVV data bases.

- The billable hours, including start time and end time, for the scheduled service must match the timesheet; in the event there is a mismatch between the submitted timesheet and the EVV record, the request for unit release or approval of manual confirmation will be denied.

- Recurrence and ongoing requests for unit releasing or manual confirmation request for claim submissions are cause for heightened review of data base maintenance and probable cause for corrective action.
Overall Provider Compliance

Overall Provider compliance will be calculated by averaging the compliance percentages of each metric above.
- Providers that maintain a minimum 90 percent compliance score will be considered a preferred Provider.
- Providers with preferred Provider status will be considered first for Member referrals.

Compliance Monitoring Process

BlueCare will utilize EVV reports claims submission data to determine Provider compliance. Monitoring activities will be conducted the first week of each month for the previous month’s performance.

Providers will receive monthly EVV Compliance Reports detailing the Provider’s performance of the previous month. Providers are expected to review each report upon receipt and take appropriate actions to obtain EVV compliance where applicable. Technical assistance and support will be provided by the BlueCare Provider Network Manager. If Provider performance warrants, BlueCare may require the provision of technical assistance and support to develop and implement a corrective action plan. Providers have access to reports that may be generated by their EVV Coordinators and obtained on an ad hoc basis to maintain compliance. Providers are encouraged to utilize these reports to achieve maximum compliance with the EVV Compliance Plan.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Provider Compliance Plan</td>
<td>A set of requirements that establish a standard for EVV usage that must be adhered to by Provider agencies.</td>
</tr>
<tr>
<td>Grace Period</td>
<td>A timeframe during which Provider agencies must use an EVV system and may, for billing support purposes only, use paper timesheets as backup documentation. Provider agencies that are in a grace period are not subject to liquidated damages, contract actions, or corrective action plan requirements for failing to achieve a compliance plan score of at least 90% any of the compliance standards. Grace periods are usually the first three (3) months for newly contracted Provider approved as a participating Provider in the BlueCare network. However, claims may still be subject to denial or recoupment.</td>
</tr>
<tr>
<td>Provider Compliance Plan Review Period</td>
<td>The standard review period will be each month. Additionally, Providers may receive ad hoc reviews as required by BlueCare when the performance of a Provider deems more frequent reviews and monitoring.</td>
</tr>
<tr>
<td>Manual Confirmations</td>
<td>Any EVV Member visit that is confirmed without any EVV usage.</td>
</tr>
<tr>
<td>Data Base Maintenance</td>
<td>Activities required to maintain Provider and Member data, including PCSP attestations, exceptions and reason code population, and any other tasks required to have accurate and timely information pertaining to monitoring and billing for LTSS services.</td>
</tr>
</tbody>
</table>

Any questions pertaining to the BlueCare Compliance Program should be directed to the CHOICESProviderRelations@bcbst.com email box.
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I. Introduction

The Division of TennCare established a TennCare Select program called SelectCommunity. SelectCommunity is an integrated Care Management Program created within TennCare Select for certain persons with intellectual disabilities. The program is open to persons enrolled in one of the State’s three (3) Section 1915(c) Home and Community Based Services Waiver programs for persons with intellectual disabilities, as well as former Arlington Class members residing in a private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

All SelectCommunity Members are assigned a Nurse Care Manager who serves as the Member’s and Provider’s primary point of contact for physical and behavioral health needs. Members enrolled in the CHOICES Long-Term Services and Supports (LTSS) Home and Community-Based Services (HCBS) Program (see Section XXII. CHOICES in this Manual) or in the ECF CHOICES Employment and Community First Program (see Section XXIII. ECF CHOICES in this Manual) are not eligible to be enrolled in the SelectCommunity program at the same time.

All claims for care provided to SelectCommunity Members must be submitted through Availity, BlueCare Tennessee’s secure web portal on http://bluecare.bcbst.com/.

If you are already registered, look for the “Availity” login box located in the top right-hand corner of the Web page to submit claims electronically, or view information just as it appears right now in our computer system. If you are not registered, go to http://www.Availity.com and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

Note: This process does not apply to CHOICES/ECF CHOICES Members, only to SelectCommunity Members.

All participating TennCare Select Providers are eligible to provide services to SelectCommunity Members. The SelectCommunity Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of SelectCommunity Members. SelectCommunity PCPs utilize the TennCare Select Network for specialty, facility, and ancillary care. In exchange for the fulfillment of these roles and responsibilities, an enhanced care management fee is paid for each SelectCommunity Member who is assigned to their practice. No minimum enrollment is required.
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II. How to Identify SelectCommunity Members

A. Determining Eligibility

The State of Tennessee determines Member eligibility for the SelectCommunity Program. Only the State of Tennessee can enroll Members in the SelectCommunity Program.

B. Enrollment of SelectCommunity Member

On September 1, 2012, the initial “opt in” process was completed in all three (3) Grand Regions. Eligible Members now have the option to “opt in” the SelectCommunity Program at any time. To initiate the transition, the Member or a responsible party must call the TennCare Solutions Unit at 1-800-878-3192 to request enrollment in SelectCommunity.

C. ID Card

Each SelectCommunity Member receives a plastic Member ID card reflecting his/her Primary Care Provider (PCP) name and effective date. A new ID card is issued each time the Member changes his or her PCP.

Note: Medicare/Medicaid dual-eligible Members are not required to seek care from a PCP for their care, except for Medicare non-Covered Services that are SelectCommunity-covered.

The SelectCommunity ID card provides the following information:
- Member name;
- Member ID number;
- Effective date (the date the Primary Care Provider assignment is effective);
- Assigned Primary Care Provider;
- Member liability (if applicable);
- Member’s Date of Birth;
- Prior authorization information;
- TennCare eligibility classification;
- Benefit level; and
- Copayment (if applicable)

A sample copy of the SelectCommunity Member ID card follows:

For inquiries or to arrange authorizations call:

Provider/Member Services
Telephone 1-800-292-8196

Utilization Management
(Notification/Prior Authorization)
Telephone 1-800-292-8196
D. PCP Membership Listing

The PCP Membership Listing is a report providing PCPs with eligibility information for those Members assigned to his/her membership based on the PCP’s network participation status, e.g. BlueCare, TennCare Select, SelectCommunity and/or Best Practice Network. The listing is comprised of enrollment information received from the Bureau of TennCare. Any Member eligibility changes received from the state subsequent to the issuance of the report are reflected on the following month’s PCP Membership Listing.

Effective June 15, 2010, based on positive Provider feedback, BlueCare, TennCare Select, and Best Practice Network PCP Providers no longer receive their membership listings via mail. Rather, the listings are available electronically via Availity, BCBST’s secure area on its company websites, http://bluecare.bcbst.com and www.bcbst.com. If you are not registered, go to http://www.Availity.com and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard.

If you need assistance, contact our eBusiness Service Center at 423-535-5717 or e-mail Ecomm_TechSupport@bcbst.com.

Once logged on to Availity, select “Additional Provider Services”. Membership listings are located under the “PCP Member Roster” heading.
III. SelectCommunity Provider Roles and Responsibilities

The SelectCommunity Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of SelectCommunity Members. In exchange for the fulfillment of these roles and responsibilities, an enhanced care management fee is paid for each SelectCommunity Member who is assigned to their practice. No minimum enrollment is required.

A. PCP Responsibilities

- PCP may be included as part of the Care Management Support Team;
- Consult with the Nurse Care Managers in the development of the Member’s Integrated Plan of Health Care;
- Provide not only the basic health care, but also care coordination of all the health care services for assigned SelectCommunity Members;
- Refer Member to physical and behavioral health professionals in the TennCare Select Network for specialty care;
- Request telephone consultations with experts in Intellectual and/or Developmental Disabilities when indicated with assistance from the BlueCare Tennessee Nurse Care Manager;
- Communicate with caregivers on the plan of care;
- Maintain health information on all physical and behavioral health services for assigned SelectCommunity Members regardless of who has provided these services;
- Forward medical files to a newly assigned PCP and provide an initial consult when the SelectCommunity Member is transferred to a new PCP;
- Forward pertinent information to providers seeing SelectCommunity Members on referral;
- Utilize best practice guidelines for acute and chronic conditions common to persons with Intellectual Disabilities when implemented and distributed by BlueCare Tennessee. BlueCare Tennessee shall implement, distribute and train and monitor PCPs and specialists regarding the use of best practice guidelines for acute and chronic conditions common to persons with ID;
- Review information provided by the State or BlueCare Tennessee on caring for persons with Intellectual Disabilities;
- Participate in training related to health problems of persons with Intellectual Disabilities or best practice guidelines;
- Assist in the development of the Integrated Plan of Health Care, and incorporate all the treatment needs of the SelectCommunity Members they see; and
- Work closely with BlueCare Tennessee’s Nurse Care Manager in the coordination of care for SelectCommunity Members, including notifying the Nurse Care Manager as expeditiously as warranted by the Member’s circumstances, of any significant changes in the Member’s condition or care, hospitalizations, or recommendations regarding physical or behavioral health services that may be needed.

B. Referrals for Specialty Care

SelectCommunity PCPs should utilize the TennCare Select Network for specialty, facility, and ancillary medical care.
C. Coordination of Care

Coordination of care is an integral process that ensures continuity of care for SelectCommunity Members. When services are rendered to a SelectCommunity Member, the Provider rendering the service should communicate the information related to the encounter to the SelectCommunity PCP either through the SelectCommunity Medical Record Update form or via letter, which contains the information requested on the form.

D. PCP Care Management Fee

SelectCommunity PCPs receive a $10.25 per Member per month Care Management Fee as compensation for their agreement to fulfill the SelectCommunity Network PCP Roles and Responsibilities. The SelectCommunity Care Management Fee is in lieu of the TennCareSelect Management Fee and no minimum enrollment is required.

E. Preventive Care

Every SelectCommunity Member should receive checkups, even if there is no apparent health problem. The SelectCommunity PCP is expected to provide a “medical home” for the SelectCommunity Members assigned to him/her. SelectCommunity Members may pose special management issues because they may have incomplete or poorly documented health records and they may present to the SelectCommunity PCP without a reliable medical history.

The SelectCommunity PCP may provide preventive services. The following offers guidelines when preventive services are appropriate:

- If the Member had a screening on schedule and the record is available, and there is no indication that an inter-periodic screen is indicated (untreated or worsening medical or behavior problem), then there is no need to repeat the screen.

- A repeat screen is indicated if the results of the last screen are:
  - not available; or
  - the last screen identified problems that were not followed-up; or
  - identified problems have worsened or persisted; or
  - there is reason to suspect abuse.

- If the SelectCommunity Member presents to the SelectCommunity PCP with an inadequate history and unreliable historian, the SelectCommunity PCP should complete as much screen as possible, notify the Nurse Care Manager of what additional information is needed, and reschedule the Member for a follow-up interperiodic exam (See Section XX. TennCare Select Kids in this Manual for details on Interperiodic Screening).

1. Preventive Screening

Periodic screening examinations have the following seven required components:

1. Comprehensive health and developmental history (including assessment of physical and mental health development and dietary practices);
2. Comprehensive unclothed physical examination including measurements (the child’s growth shall be compared against that considered normal for the child’s age and gender);
3. Appropriate immunizations scheduled according to the most current Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history;

4. Appropriate vision and hearing testing provided at intervals which meet reasonable standards of medical practice and at other intervals as Medically Necessary to determine the existence of suspected illness or condition;

5. Appropriate laboratory tests (including lead toxicity screening for age and risk factors). All children are considered at risk and shall be screened for lead poisoning; and

6. Dental screening services furnished by direct referral to a dentist for children no later than 3 years of age and should be referred earlier as needed (as early as 6 to 12 months in accordance with the American Academy of Pediatric Dentistry (AAPD) guidelines) and as otherwise appropriate; and

7. Health Education which includes anticipatory guidance.

Note: Pursuant to requirements outlined in the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual, Part 5, Section 5320A, Providers are required to have a process for documenting services declined by a parent or guardian or mature competent child specifying the particular service declined. Additionally, Providers are required to have a process for documenting services declined by an authorized representative, guardian, or conservator for adults specifying the particular service declined.

2. Periodicity Schedule and Preventive Visit Forms

The periodicity schedule defines the intervals for screening and is based on American Academy of Pediatric recommendations (1999), and Division of TennCare guidelines. The Periodicity Schedule should be used in determining the correct ages to perform preventive visits as well as to determine the age-appropriate screening. More frequent screening should be done as medically indicated. All of the age-appropriate screening components must be completed in each preventive checkup visit.

Guidelines, periodicity schedules, standard preventive visit encounter forms, and standard development screening tools can be found in the TennCare Kids Tool Kit located on the BlueCare Tennessee website at https://bluecare.bcbst.com/providers/tools-resources/general/programs-services-faqs.html.

3. Preventive Care Billing Guidelines

Coding preventive services using appropriate preventive CPT® codes will help ensure Providers receive the highest level of benefits possible. See Section XIV. Preventive Care in this Manual for specific preventive care billing guidelines.
IV. Nurse Care Manager

The Nurse Care Manager is the primary point-of-contact for all Members, caregivers, and Providers.

Each SelectCommunity Member is assigned a Nurse Care Manager who is responsible for developing an individualized, Integrated Plan of Health Care for each Member coordinating physical and behavioral health services. The Nurse Care Manager’s purpose is to facilitate a seamless access to care and maximize health outcomes of SelectCommunity Members.

Nurse Care Managers must possess an active Tennessee Registered Nurse License or hold a license in the state of their residence if the state is participating in the Nurse License Compact Law. A minimum of three years of clinical nursing experience is required and five years health care experience is preferred.

All Nurse Care Managers who meet established qualifications but are not Certified Case Manager (CCM) and Certified Developmental Disabilities Nurse (CDDN) certified upon employment are required to complete such certification(s) upon obtaining the minimum experience. Extensive training related to the needs of the target population is provided to newly hired Nurse Care Managers and ongoing training occurs at least annually for all Nurse Care Managers and Supervisors.

Case management and/or disease management activities are integrated along with the Nurse Care Management processes and functions. Care management tools, health informatics and analytics to stratify populations and target physical and behavioral health interventions are used to manage the Member’s care and identify and address gaps in care.

Responsibilities

- Conduct all needs assessment and care planning activities, and make all minimum care management contacts in the Member’s place of residence, except under extenuating circumstances;
- Assess each Member’s need for contact with the Nurse Care Manager to help ensure that the Member’s physical and behavioral health needs are met;
- Perform a comprehensive face-to-face assessment of each Member’s physical, behavioral health, developmental and social needs;
- Identify covered physical and behavioral health services that are necessary to meet the Member’s needs;
- Develop and maintain for each Member an individualized, Integrated Plan of Health Care;
- Establish timely access to and provision, coordination and monitoring of covered physical and behavioral health services; and
- Collaboration between Providers and payers of the Member’s physical and behavioral health services, including Physicians and other physical and behavioral health care Providers, TennCare, Medicare, and Department of Intellectual Disabilities (DID).
- For persons residing in Institutional Placements, the Integrated Plan of Health Care shall supplement the facility’s plan of care (which is required pursuant to federal regulation), and shall focus on the provision of services covered by TennCareSelect that are beyond the scope of the Institutional ICF/IID or NF benefit, including targeted strategies related to improving health, functional, or quality of life outcomes (e.g., related to disease management or pharmacy management) or to increasing and/or maintaining health and/or functional status, as appropriate.
Upon completion of the assessment, the Nurse Care Manager:

- works with a Care Management Team including the Member and Member’s family, to develop an individualized, Integrated Plan of Health Care within thirty (30) calendar days of enrollment into SelectCommunity;
- consults with the Member’s Primary Care Provider, specialists, behavioral health Providers, other Providers, and interdisciplinary team experts, as needed during the development of the Integrated Plan of Health Care;
- updates the Integrated Plan of Health Care as needed to reflect significant changes in condition, treatments or interventions, risks and interventions, and physical and behavioral health needs and services;
- At a minimum, Members participating in the Integrated Health Services Delivery Model with complex unstable physical or behavioral health needs shall be visited in their residence face-to-face by their Nurse Care Manager at least monthly;
- At a minimum, Members participating in the Integrated Health Services Delivery Model with complex stable physical or behavioral health needs shall be contacted by their Nurse Care Manager at least monthly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least quarterly;
- At a minimum, Members participating in the Integrated Health Services Delivery Model with no complex physical or behavioral health needs shall be contacted by their Nurse Care Manager at least quarterly either in person or by telephone, and shall be visited in their residence face-to-face by their Nurse Care Manager at least semi-annually; and
- Reassess physical and behavioral health needs at least annually and within five (5) business days of the Nurse Care Manager becoming aware that the Member’s functional, physical, or behavioral status has changed significantly.

Nurse Care Managers also have an integral role in all care transitions, including discharge from an inpatient acute or psychiatric hospital setting, transition from an Institutional to HCBS setting, and transitions between Institutional settings. The Nurse Care Manager, working with the discharge planner, ISC or Waiver Case Manager, and family, determines the physical and/or behavioral health services that will be needed upon discharge, and establish that such services are arranged and provided in a timely manner.

The Nurse Care Manager monitors home health, private duty nursing, occupational, physical and speech therapy services to determine that they are implemented timely and in compliance with the Integrated Plan of Health Care. Identified service gaps are addressed immediately and backup plans are implemented. Service gaps are evaluated to determine their cause and to minimize gaps going forward.

Member Emergency Department and behavioral health crisis service utilization are evaluated to determine the reason for these visits. The Nurse Care Manager takes appropriate action to facilitate appropriate utilization of these services, communicates with the Member’s Care Management Team and provides thorough documentation in the member’s Integrated Plan of Health Care education and needs assessments and actions that have occurred.
SelectCommunity PCPs have agreed to maintain health information on all physical and behavioral health services for assigned SelectCommunity Members regardless of who provided the services. The SelectCommunity Medical Record Update form may be used to facilitate this comprehensive medical record. See Section XVII. Credentialing in this Manual, for additional medical record requirements.

The SelectCommunity PCP Medical Record Update form can be found on the BlueCare website at https://bluecare.bcbst.com/providers/forms.html.
SelectCommunity is an Integrated Care Management Program created within TennCareSelect for certain persons with Intellectual Disabilities. As such, SelectCommunity Member benefits are the same as all other TennCareSelect covered benefits. Additionally, all medical management and billing guidelines apply. The grid below directs you to the appropriate sections in your BlueCare Tennessee Provider Administration Manual for general information and specific policies and procedures as they relate to the TennCareSelect Program:

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Glossary

These term definitions have been edited for this medium and are not as complete or detailed as some of the glossary definitions that come with BlueCare Tennessee contracts.

Ambulance: A specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Facility: An Institution which:

1. primarily performs surgical procedures on an outpatient basis;
2. does not provide inpatient care;
3. has an organized staff of Practitioners and permanent facilities and equipment;
4. may not be primarily used as an office or clinic for a Practitioner’s or Other Professional’s practice; and
5. is a licensed Institution.

Annual Benefit Period: The 12-month period under which the Member’s benefits are administered.

Business Day: Any day falling within the five (5)-day work week, (Monday through Friday).

Calendar Day: Any day falling within the seven (7)-day week, (Monday through Sunday).

Calendar Year: See “Annual Benefit Period”.

Coinsurance: The portion of an eligible medical bill a Member must pay out-of-pocket before BlueCare Tennessee begins paying insurance benefits. Coinsurance amounts are usually a percentage of the total medical bill, i.e., 20 percent. Coinsurance applies after the Member meets a required Deductible or Copay amount. Coinsurance is part of certain health plans.

Concurrent Review: A determination of whether continued inpatient care, or a given level of services being received, is Medically Necessary for the Member’s medical condition. This review can be performed by the Provider’s utilization review staff, BlueCare Tennessee’s review coordinator or Medical Director, or any other entity or organization under contract with BlueCare Tennessee. Once the case is reviewed, BlueCare Tennessee will notify the Practitioner and the Member of the results.

Copay or Copayment: A copay is a fixed-dollar amount that a Plan Member pays to a participating network doctor, caregiver, or other medical Provider or pharmacy each time health care services are received. A Copay is paid before BlueCare Tennessee pays the covered benefit amount. Copays are part of certain health care plans.

Contract: The entire agreement between BlueCare Tennessee and the Member, including a contract document, the signed application and any attached papers or riders. A rider is an extra provision that is added to the basic Contract. BlueCare Tennessee considers the statements an individual makes in the application to be representations, not warranties.

Contract Date or Effective Date: The date coverage begins.

Covered Service: A Medically Necessary service or supply shown in the Contract for which benefits may be available.

Custodial Care: Care provided primarily for maintenance designed to assist the Member in activities of daily living. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.
Deductible or Deductible Amount: A Deductible is a fixed-dollar amount that a Member must pay for eligible services before BlueCare Tennessee begins applying insurance benefits. Usually Deductibles apply every calendar year. Deductibles are part of certain health care benefits plans.

Dependent: Another family member covered under a Member’s health care benefits plan. May be a spouse and/or unmarried children who meet eligibility requirements of the Plan.

Diagnostic Service: A procedure ordered by a Practitioner or Other Provider to determine a specific condition or disease. Some common diagnostic procedures include:

1. X-rays and other radiology services;
2. laboratory and pathology services; and
3. cardiographic, encephalographic and radioisotope tests.

Durable Medical Equipment (DME): Equipment which:

1. can only be used to service the medical purpose for which it is prescribed;
2. is not useful to the Member or other person in the absence of illness or injury;
3. is able to withstand repeated use; and
4. is appropriate for use in an ambulatory or home setting.

Such equipment will not be considered a Covered Service, even if it is prescribed by a Practitioner or Other Provider simply because its use has an incidental health benefit.

Effective Date: The date on which coverage begins for a Member.

Eligible Person: A person entitled to make application for coverage.

Emergency or Emergency Medical Condition: Emergency medical condition means a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.

Emergency Admission: Admission as an Inpatient in connection with an Emergency.

Emergency Services: Health care services and supplies furnished in a hospital which are needed to determine, evaluate and/or treat an emergency medical condition until the condition is stabilized, as directed or ordered by a Practitioner or hospital protocol.

Fee Schedule or Fee for Services: The maximum fee that BlueCare Tennessee will pay for specified Covered Services.

Freestanding Diagnostic Laboratory: An Other Provider that provides laboratory analysis for other Providers.

Freestanding Dialysis Facility: A Facility Other Provider that provides dialysis treatment, maintenance, and training to Members on an outpatient or home health care basis.

Freestanding Sleep Study Center: A Facility Other Provider that provides sleep studies on an outpatient basis.

Health Care Professional: A Podiatrist, Dentist, Chiropractor, Nurse Midwife, Registered Nurse, Optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which that health Care Professional practices.

Home Health Care Agency: An Other Provider, which is primarily engaged in providing home health care services.

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Hospital: A short-term, acute-care, general hospital which:

1. is a licensed institution;
2. provides inpatient services and is compensated by or on behalf of its patients;
3. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;
4. has a staff of Practitioners licensed to practice medicine; and
5. provides 24-hour nursing care by registered graduate nurses.

A facility which serves, other than incidentally, as a nursing home, custodial care home, health resort, rest home, rehabilitative facility or place for the aged is not considered a hospital.

In-Network: Practitioners, caregivers and medical facilities are considered “in-network” if they participate in an agreement with BlueCare Tennessee to provide services according to specific terms and rates.

Inpatient: Inpatient medical care is when treatment is provided to a Member who is admitted as a bed patient in a hospital or other medical facility, and room and board charges are incurred. For behavioral health benefits, Inpatient care can refer to treatment received at a hospital, a behavioral health facility or a behavioral health program. Most benefit plans require prior authorization for Inpatient care before a Member is admitted to a hospital, skilled nursing facility or rehabilitation facility.

Investigational: A drug, device, treatment, therapy, procedure, or other services or supplies that do not meet the definition of Medical Necessity:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of its use or proposed use;
2. is the subject of a current investigational new drug or new device application on file with the FDA;
3. is being provided according to a Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (participation in a clinical trial shall not be the sole basis for denial);
4. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives;
5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS);
6. the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is Investigational or that there is insufficient data to determine if it is clinically acceptable;
7. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings;
8. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives; and/or
9. the service or supply is required to treat a complication of an Investigational service.

The Medical Director shall have discretionary authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all the following, at his or her discretion:

1. Member’s medical records;
2. the protocol(s) under which proposed service or supply is to be delivered;
3. any consent document that has been executed or the Member is asked to execute, in order to receive the proposed service or supply;
4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses;
5. regulations or other official publications issued by the FDA and/or HHS;
6. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services; and/or
7. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

**Maximum Allowable Charge:** The highest dollar amount of reimbursement by BlueCare Tennessee for a Covered Service. This amount is based on the rates or fees negotiated between BlueCare Tennessee and certain Practitioners, Health Care Professionals, or Other Providers, and whether Covered Services are received from a participating or non-participating Provider. Reimbursement for Out-of-Network services will be the stated percentage of the Maximum Allowable Charge or Billed Charges, whichever is less.

**Medical Care:** Professional services by a Practitioner or Professional Other Provider to treat an illness, injury, pregnancy, or other medical condition.

**Medically Appropriate:** Services, which have been determined by the Medical Director of BlueCare Tennessee to be of value in the care of a specific Member. To be Medically Appropriate, a service must:

1. Be Medically Necessary.
2. Be used to diagnose or treat a Member’s condition caused by disease, injury or congenital malformation.
3. Be consistent with current standards of good medical practice for the Member’s medical condition.
4. Be provided in the most appropriate site and at the most appropriate level of service of the Member’s medical condition.
5. On an ongoing basis, have reasonable probability of:
   - correcting a significant congenital malformation or disfigurement caused by disease or injury;
   - preventing significant malformation or disease; or
   - substantially improving a life-sustaining bodily function impaired by disease or injury.
6. Not be provided solely to improve a Member’s condition beyond normal variation in individual development and aging including:
   - Comfort measures in the absence of disease or injury; or
   - Improving physical appearance that is within normal individual variation.
7. Not be for the sole convenience of the Provider, Member or Member’s family.
8. Not be an Investigational service.

**Medically Necessary or Medical Necessity:**
“Medically Necessary” are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.
Medicare: The program of health care for the aged and disabled established by Title XVIII of the Social Security Act as amended.

Member: Any person covered under a health plan from BlueCare Tennessee, including that person’s eligible spouse and/or eligible, unmarried children.

Nervous and Mental Disorder: A condition characterized by abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Nervous and Mental Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement. Nervous and Mental Disorders include alcohol, drug or chemical abuse or dependency, but do not include learning disabilities, attitudinal disorders, or disciplinary problems.

Non-Compliance: Services rendered without obtaining a prior authorization prior to services being rendered are considered to be non-compliant.

Non-Participating Provider: A Practitioner, hospital or ambulatory surgical facility that has not contracted with BlueCare Tennessee to furnish services and to accept specified levels of payment, plus applicable Deductibles and Copayment amounts, as payment in full for Covered Services.

Other Provider: An individual or facility, other than a Hospital or Practitioner, duly licensed to render Covered Services.

1. The following institutions are Facility Other Providers which may provide Covered Services:

   - Freestanding Dialysis Facility;
   - Ambulatory Surgical Facility;
   - Skilled Nursing Facility;
   - Substance Abuse Treatment Facility;
   - Residential Treatment Facility; and/or
   - Licensed Birthing Center.
   - Ambulatory Infusion Center
   - Health Department
   - Outpatient/Inpatient Rehabilitation Facility
   - Sleep Lab

2. The following Professional Other Providers may provide services covered by certain BlueCare Tennessee Contracts. In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a Practitioner within this specialty or degree. All services or supplies must be rendered by the Practitioner actually billing for them and be within the scope of his or her Licensure.

   - Doctor of Osteopathy (OD);
   - Doctor of Dental Surgery (DDS);
   - Doctor of Dental Medicine (DDM);
   - Doctor of Optometry (OD);
   - Doctor of Podiatric Medicine (DPM);
   - Doctor of Chiropractic (DC);
   - Licensed Clinical Social Worker (LCSW);
   - Licensed Independent Practitioners of Social Worker (LIPSW);
   - Licensed Marriage and Family Therapist (LMFT);
   - Licensed Practical Nurse (LPN);
   - Licensed Professional Counselor (LPC)
   - Licensed Psychological Examiner (LPE) supervised in accordance with Tennessee law
   - Licensed Psychologist;
Nurse Midwife (NM), licensed as a RN and certified by the American College of Nurse Midwives;
Registered Nurse (RN), including an RN who is a nationally-certified Nurse Practitioner (NP), Nurse Anesthetist (NA), Lactation Specialist, or Clinical Specialist (CS);
Registered Nurse Anesthetist (RNA);
Registered Physiotherapist (RPT);
Licensed Pharmacist (D. Pharm.);
Occupational Therapist (for services to restore functioning of the hand following trauma only);
Registered Dietitian or Nutritionist approved by BlueCare Tennessee;
Licensed Genetic Counselor; and/or
Physician Assistant (PA).

3. The following Other Providers may also provide services covered by certain BlueCare Tennessee Contracts:

- Suppliers of durable medical equipment, appliances and prosthesis;
- Suppliers of oxygen;
- Certified ambulance service;
- Hospice;
- Pharmacy;
- Freestanding Diagnostic Laboratory;
- Freestanding Sleep Study Center;
- Home Health Care Agency;
- Home Infusion Therapy;
- Outpatient Diagnostic; and/or
- Pain Management Center.

Out-of-Network Provider: A Practitioner, caregiver or medical facility that does not participate in an agreement with BlueCare Tennessee to provide services according to specific terms and rates.

Out-of-Pocket Maximum: The dollar amount, which a Member must pay for Covered Services during a benefit period.

Outpatient: Outpatient medical care is when treatment is provided to a Member in a facility or setting where room and board charges are not incurred. Outpatient medical services may be provided in a Practitioner’s office, the Outpatient department of a hospital, or in some other medical setting. For behavioral health benefits, Outpatient care refers to routine visits to a behavioral health professional. Most benefit plans require prior authorization for certain Outpatient medical services.

Outpatient Surgery: Surgery performed in an Outpatient department of a hospital, Practitioner’s office or Facility Other Provider.

Physical Therapist: A licensed Physical Therapist. (In states where there is no Licensure required, the Physical Therapist must be certified by the appropriate professional body or accrediting organization.)

Participating Provider: A Practitioner, Hospital, or Ambulatory Surgical Facility or Other Health Care Provider that has contracted with BlueCare Tennessee to furnish services and to accept BlueCare Tennessee payment for Covered Services after applicable Deductibles, Coinsurance or Copayment amounts have been paid by the Member.

Practitioner: A licensed Practitioner legally entitled to practice medicine and perform surgery. All Practitioners must be licensed in Tennessee or in the state in which Covered Services or rendered.

Preferred Provider Organization (PPO): A PPO plan offers a network of Practitioners, caregivers and medical facilities that agree to provide health care services to Members at less than the usual service fees. Members receive the highest level of benefits when network Providers are used. Members may seek medical care outside the network, but benefits are reduced substantially.
Primary Care Provider (PCP): A Practitioner selected by the Member to coordinate all his or her health care, including routine checkups and treatment for medical conditions. A PCP is usually a Practitioner in general practice, family practice, internal medicine or pediatrics. Certain health plans require the Member to select a PCP.

Prior Approval: See “Prior Authorization”.

Prior Authorization: Prior Authorization verifies the Medical Necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, Prior Authorization helps determine cost-effective alternatives for certain prescription drugs.

Provider: A Provider is a Practitioner, other professional caregiver, medical facility, or medical supplier that supplies health care.

Referral: The process by which a PPO Member’s Primary Care Practitioner authorizes treatment from a medical specialist.

Skilled Nursing Facility (SNF): A facility, which provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Practitioner.

Specialist: A Specialist is a Practitioner highly trained in a specific area. Specialists may refer to a sub-Specialist in complex cases. Some examples of a Specialist include:

- Cardiologist
- Dermatologist
- Neurologist
- Obstetrician
- Podiatrist
- Psychiatrist

Surgery: Surgery is defined as follows:

1. operative and cutting procedures, including use of special instruments;
2. endoscopic examinations (the insertions of a tube to study internal organs) and other invasive procedures;
3. treatment of broken and dislocated bones;
4. usual and related pre-and post-operative care when billed as part of the charge for Surgery; and
5. other procedures that have been approved by BlueCare Tennessee.

Termination Date: The date a Contract ends and the date Benefits end.

Therapy Services: Services for treatment of illness or injury defined below:

1. Radiation Therapy – treatment of disease by X-ray, radium, or radioisotopes;
2. Chemotherapy – treatment of malignant disease by chemical or biological agents;
3. Dialysis – treatment of a kidney ailment, including the use of an artificial kidney machine;
4. Physical Therapy – treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part;
5. Respiratory Therapy – introduction of dry or moist gases into the lungs; and
6. Home Infusion Therapy (HIT) – therapy in which fluid or medication is given intravenously, subcutaneously, intramuscularly, or epidurally, at the patient’s home, including total Parenteral Nutrition, Enteral Nutrition, Hydration Therapy, Chemotherapy, and Aerosol Therapy and Intravenous Drug Administration.
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Appendices

Appendix A  Member Rights, Responsibilities and Appeals
Appendix B  Quality Assurance and Grievance Management
Appendix C  Trip Reimbursement Form
Appendix D  Vehicle Inspection Forms
Appendix E  Passenger Assistance & Sensitivity Skills Training Program
Appendix F  NEMT Requirements
On January 1, 1994, Tennessee began a new health care reform program called TENNCARE. This program, which required no new taxes, essentially replaced the Medicaid program in Tennessee. TENNCARE was designed as a managed care model. It extended coverage to uninsured and uninsurable persons who were not eligible for Medicaid.

The TENNCARE program was implemented as a five-year demonstration program approved by the Centers for Medicare and Medicaid Services (CMS). The program received several extensions and renewals after the original expiration date of December 30, 1999, and is currently approved through June 30, 2010.

The current TENNCARE program is really two programs. TENNCARE Medicaid is for persons who are Medicaid eligible, and TENNCARE Standard is for persons who are not Medicaid eligible but who have been determined to meet the state’s criteria as being either uninsured or uninsurable. Historically, individuals in both programs have received the same services. TENNCARE Standard members with family incomes at or above poverty are required to pay premiums and co pays, however.

TENNCARE services are offered through several managed care entities. Each member has a Managed Care Organization (MCO) who provides both physical and behavioral health services, and a Pharmacy Benefits Manager (PBM) for his pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a Dental Benefits Manager (DBM). The state added its own MCO, called TennCareSelect, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCareSelect is administered by BlueCare Tennessee (BCT).

In addition to the TENNCARE managed care programs, the Division of TENNCARE administers certain long-term care services. These include care in Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), as well as several Home and Community Based Services (HCBS) waiver programs which will serve as alternatives to long-term care in the future. TENNCARE also handles Medicare cost-sharing payments for eligible individuals.

Each MCO is responsible for the management of Non-Emergency Medical Transportation (NEMT) services for all covered TENNCARE services (except HCBS) within their contracted regions of the state, even if the service is not covered by the MCO. In many cases, MCO’s have contracted with transportation management companies, or brokers, to administer this function. BlueCare Tennessee has contracted with Southeastrans, Inc. to manage all NEMT services for BlueCare/TennCareSelect members enrolled under their TENNCARE Managed Care Plan.
Southeastrans (broker) specializes in management of Medicaid non-emergency medical transportation utilizing proven concepts to assure that Medicaid members receive quality transportation services in a prompt and safe manner. These concepts include the operation of a centralized call center with specialized software for scheduling and assigning NEMT trips. Southeastrans also has policies and procedures in place for the detection of fraud and abuse. We are responsible for the development of a transportation provider network through contracts with independent and public transportation providers, as well as quality monitoring and improvement functions. Additional administration roles of Southeastrans include NEMT provider payment functions, compliance and regulatory functions, data analysis, and reporting.

More specifically, Southeastrans has responsibility to:

1. Receive calls requesting NEMT services. The member should contact Southeastrans to request NEMT services at least 72 hours before the NEMT services is needed. Advance scheduling is requested for all NEMT services except urgent care and follow-up appointments when the time frame does not allow advance scheduling. There is no time limit for scheduling transportation for future appointments.

2. Determine eligibility through the completion of a computerized phone script and data entry procedures at the time of contact for each request accumulating information on the member and the trip request.

3. Determine that each trip is to a TENNCARE covered service, that the member is eligible for TENNCARE on the day the services will be provided, and all other pertinent information relating to the trip.

4. Determine the availability of suitable transportation and decide how to provide the trip using the most appropriate mode of transportation, including federally funded public transportation.

5. Determine any special needs of the TENNCARE member concerning mode of transportation needed, services needed en route and/or the need for an escort.

6. Assign the trips to the most appropriate NEMT provider. Southeastrans is not required to use a particular NEMT provider or driver requested by the member. However, we may accommodate a member’s request to have or not have a specific NEMT provider or driver.

7. Only authorize trips for eligible members to covered services as defined by TENNCARE guidelines.

8. Transmit all NEMT providers’ upcoming trips to them via fax or e-mail.
9. Follow up to ensure that the trip was provided in a safe and timely manner. (This includes the duties related to trip reconciliation and billing.)

10. Reconcile trip charges with contracted NEMT providers, resolving discrepancies and/or reporting problems and paying the providers in a timely manner.

11. Offer Passenger Assistance Training (“PAT”) and other required training for all drivers of Transportation providers under agreement with the Southeastrans.

12. Provide an orientation program for Transportation Providers.

13. Perform annual vehicle inspections of Transportation providers’ vehicles.

14. Perform periodic quality review of all Transportation Providers, both statistical and on-site, involving Transportation Provider compliance with contractual standards and requirements.

15. Perform periodic and causal audits of NEMT providers to determine compliance with contractual requirements, reporting and billing.

Southeastrans Office Locations and Contact Numbers

Southeastrans’ Tennessee Call Center is located at:

    Osborne Office Park  
    5751 Uptain Road, Suite 300  
    Chattanooga, TN 37411  
    Office: 423-893-8282  
    Fax: 423-893-8225

Southeastrans Corporate Office is located at:

    4751 Best Road  
    Suite 300  
    Atlanta, GA 30337  
    Phone: 678-510-4600  
    Fax: 404-762-8443

BlueCare Tennessee Contact Numbers

    BlueCare Provider Customer Service: 1-800-468-9736
    TennCareSelect Provider Customer Service: 1-800-276-1978

Overview of Southeastrans Staff Functions

The following Southeastrans positions are your points of contact within the Southeastrans organization:
Chief Operations Officer (COO) – Oversees all aspects of the Southeastrans operations including:

- Management of the Southeastrans executive team
- Establishment of corporate policies and procedures
- Liaison between Southeastrans and the Southeastrans Advisory Committees
- Ensuring NEMT provider payments are made timely
- Liaison between Southeastrans and BCT
- Ensuring compliance with contracting agencies

Chief Information Officer (CIO) – Oversees the Information Technology and all communications equipment including:

- Maintaining Southeastrans computer equipment
- Maintaining Southeastrans communications equipment and devices
- Ensuring all company software is operating effectively
- Ensuring all software licenses are compliant
- Protecting the network and all electronic data from intrusion from outside sources
- Working with NEMT providers to assist them in technical purchases and IT training
- Ensuring the scheduling software is in compliance with the Southeastrans Agreement with BCT
- Ensuring all reporting is submitted on a timely basis

Tennessee Operations Director – Oversees the day-to-day operations within the Tennessee service areas including:

- Developing and implementing policies and procedures
- Ensuring compliance and accountability
- Ensuring a high level of customer service
- Establishing and maintaining good working relationships with NEMT providers and healthcare providers
- Overseeing all Call Center and Customer Service personnel
- Maintaining and improving employee morale
- Working with the IT staff to ensure correct operation of all Call Center equipment and computers
- Investigating and resolving all service issues and employee and customer grievances
- Quality management and reporting functions
- Developing and managing department budget

Compliance Manager – Oversees the NEMT Provider compliance programs ensuring that all performance standards are met or exceeded including:

- Management of NEMT Compliance functions
- Delegation of duties to Regional Compliance Officers
- Management of NEMT Provider database and records
- Overseeing vehicle and driver inspections
- Ensuring NEMT providers are in compliance with their contractual obligations

Compliance Officer – Performs on-site vehicle and driver inspections, customer service surveys and compliance monitoring including:
- Maintaining regular contact with all contracted transportation providers
- Inspecting NEMT provider vehicles for safety, cleanliness and compliance
- Performing spot field checks of NEMT drivers to ensure proper identification, licensure, etc.
- Performing spot field checks of NEMT providers’ drivers to ensure proper member treatment and transportation
- NEMT provider record keeping and file management
- Other duties as assigned

Quality Manager – Oversees quality management ensuring that all performance standards are met or exceeded including:
- Grievance monitoring and grievance resolution functions
- Quality management reporting functions
- Developing and implementing quality improvement policies and procedures

Training Manager – Responsible for the credentialing and training of all NEMT providers drivers including, but not limited to:
- General Orientation to NEMT Services
- Customer Service, Courtesy, Sensitivity Awareness and Sexual Harassment
- Passenger Assistance Techniques Course
- Mental health and substance abuse issues;
- Title VI requirements (Civil Rights Act of 1964);
- HIPAA privacy requirements
- ADA requirements
- Driver conduct training
- Vehicle orientation and daily inspections
- Seat belt usage and child restraints
- National Safety Council of Defensive Driving Course (or approved equivalent)
- Wheelchair securement/safety
- Record keeping requirements
- Emergency procedures
- Emergency evacuation
- Handling and reporting accidents and incidents
- Basic First Aid & CPR (Southeastrans requires CPR training above the TENNCARE minimum requirement)
- Use of a “Spill Kit” and the removal of biohazards
- Infection control
Risk management
- Communications
- Annual road tests
- Reporting enrollee and provider fraud and abuse

Customer Service Representative (CSR) – Responsible for the receipt and processing of requests for transportation, including:
- Ensuring a high level of customer service/satisfaction
- Accurately entering all transportation requests into the scheduling computer system
- Determination of eligibility for transportation services
- Determination of appropriate level of service and member special needs
- Assignment of trips to NEMT providers
- Assisting in identifying and solving scheduling and routing problems
- Performing quality assurance reviews

What is Non-Emergency Medical Transportation?

Non-emergency medical transportation (NEMT) is defined as transportation services provided to convey members (and an escort, if required) to and from TENNCARE covered services. A covered TENNCARE service is defined as “the health care services available to TENNCARE enrollees, as defined in TENNCARE rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, and dental services provided through managed care companies (MCC’s) as well as institutional services and alternatives to institutional services (home and community based waiver services) provided by entities that are not MCC’s. TENNCARE covered services includes TennCare Kids services.”

Geographic Considerations

Transportation outside the area customarily used for health care services by the member’s immediate community shall be scheduled by Southeastrans when sufficient medical resources are not available in the area or a healthcare provider has referred the member to health care services outside of the immediate community. Out-of-state transportation is not a covered transportation service unless it is to a BlueCare/TennCareSelect participating healthcare provider or the service has been approved by BlueCare/TennCareSelect. If an eligible member request transportation to an out-of-state healthcare provider that is not a participating BlueCare/TennCareSelect provider, the request must be referred to a BlueCare/TennCareSelect Customer Service for review and approval.

If a member requests a healthcare provider located outside the access standards, and BlueCare/TennCareSelect has an appropriate healthcare provider within the access requirements who accepts new members, it shall not be considered a violation of the access requirements for BlueCare/TennCareSelect to grant the member’s request. However, in such cases BlueCare/TennCareSelect shall not be responsible for providing
transportation for the member to access care from this selected provider, and BlueCare/TennCareSelect shall notify the member in writing as to whether or not transportation will be provided for the member to seek care from the requested healthcare provider. If BlueCare/TennCareSelect is unable to meet the access standards for a member, the transportation will be provided regardless of whether the member has access to transportation.

**Transportation Scheduling Procedures**

**Member Notices**

BCT provides member notices to inform BlueCare/TennCareSelect members about the NEMT broker system, announcing Southeastrans as the new broker, including contact information and hours of operation, and other information about using NEMT services.

**NEMT Access**

Southeastrans provides functions to assure that transportation services are only approved for eligible TENNCARE members who are assigned to BlueCare/TennCareSelect as their MCO and are requesting transport to TENNCARE covered services. Members should reserve transportation services at least 72 hours prior to the appointment, unless the request qualifies as an urgent care trip. Urgent care trips include immediate needs such as hospital discharges and similar circumstances where the trip could not be scheduled in advance.

To ensure BlueCare/TennCareSelect members have access to NEMT services, Southeastrans’ Customer Service Representatives (CSRs) in our call center have a thorough understanding of the transportation service guidelines. Our computer software also maintains an active database of eligible BlueCare/TennCareSelect members.

**Approval Requirements**

All NEMT services must receive approval by Southeastrans before a trip is considered authorized. Members or healthcare providers must contact Southeastrans’ Call Center for trip approval prior to the delivery of transportation services. Southeastrans’ Call Center operates on a 24-hour basis to provide trip approvals whenever the need occurs.

Southeastrans’ standard practice is to inform the member of the transportation arrangements during the phone call requesting the NEMT service. If that is not possible, Southeastrans will obtain the member’s preferred method (e.g., phone call, email, fax)
and time of contact, and will notify the member of the transportation arrangements as soon as the arrangements are in place or within twenty-four (24) hours of receiving the request. This timeframe will be reduced as necessary to ensure the member arrives at the appointment on time. If a member does not have access to a telephone for a follow-up call or does not wish to be contacted by telephone, the Southeastrans representative will provide his or her direct dial number and a suggested time for the member to call back to obtain information for the completed trip arrangements. Information about transportation arrangements will include, but not be limited to, the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the healthcare provider to whom the member seeks transport.

Southeastrans issues trip confirmation numbers to NEMT providers for each approved trip assigned to the NEMT provider via a trip manifest. Southeastrans will send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission (e-mail), at the option of the NEMT provider. Southeastrans will ensure that provision of the trip manifest is in compliance with HIPAA requirements. All NEMT providers are required to have a dedicated telephone line(s) available at all times for faxing purposes. If any trip assignments are made after a manifest has been issued, Southeastrans must contact the NEMT provider by telephone to confirm that they will accept the trip and then fax/e-mail the trip add-on information to the NEMT provider. No payments shall be issued for trips without valid trip confirmation numbers issued by Southeastrans.

Southeastrans will also communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

Validity of Information
Southeastrans accepts information provided verbally by the member as true when evaluating or reevaluating the need for NEMT services, unless there is a reasonable cause to doubt the validity of the information provided.

Trips by ambulance may require medical care during the transport. A member may require oxygen or other medical care during the transportation that requires the service of a licensed ambulance provider. NEMT providers using ambulatory vehicles, wheelchair vans, or invalid vans are not authorized to provide medical care. If medical care is required during the transport, Southeastrans requires the healthcare provider requesting the trip to complete and submit a medical necessity statement. The medical necessity statement must indicate what type of medical care is required and should be signed by the healthcare professional ordering the transport.

Southeastrans’ NEMT services requiring an ambulance service shall be based on Medicare’s medical necessity requirements. (42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services.)
Levels of Transportation

Southeastrans CSR’s are trained to ask a series of questions about the nature of the illness or treatment, if the member has their own wheelchair (if applicable), if they are “transferable” (does not require a lift or ramp-equipped vehicle), if the scheduled treatment will disable their ability to walk, etc. These determinations automatically become part of the member’s history file and will assist the CSR when making future reservations. When the member or healthcare provider advises Southeastrans that the member’s health condition has changed, the assessment of the level of transportation needed will be reinitiated as appropriate by the CSR.

Once entered into the computer system, the program will not allow an inappropriate level of service (ambulatory, wheelchair, or stretcher) to be dispatched. However, it will allow for different modes of transportation between the “go” and “return” trips. While there may exist a difference in what the member desires as their mode of transportation versus what is appropriate, Southeastrans will determine the appropriate level of service and mode of transportation based on all facts and circumstances.

Level of service is classified as either curb-to-curb, door-to-door, or hand-to-hand. Each of these levels is defined below:

Curb-to-curb: Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the member’s needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any member. The driver shall remain at or near the vehicle and not enter any buildings.

Door-to-door: Transportation provided to members with disabilities that need assistance to safely move between the door of the vehicle and the exterior door of the passenger’s pick-up point or destination. The driver shall exit the vehicle and assist the member from the exterior door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the member throughout the transport and to the exterior door of the destination.

Hand-to-hand: Transportation of a member with disabilities from an individual at the pickup point to a healthcare provider staff member, family member or other responsible party at the destination.

Urgent Trips

Urgent trips are defined as an unscheduled episodic situation, in which there is no immediate threat to life or limb, but for which the member must be seen on the day of the request and treatment cannot be delayed.
Urgent trips must meet the same basic requirements as regular appointments except for the three (3) day advanced scheduling requirement. An urgent trip can have one (1) or multiple trip legs. Southeastrans reserves the right to request verification directly from the healthcare provider stating that the need for an urgent trip, except in cases of hospital discharges. Valid requests for urgent care transports shall be honored within three (3) hours of the time the request is made in urban areas and four (4) hours in non-urban areas. Areas are designated as urban and non-urban as described by the U.S. Census Bureau. Trip mileage does not determine if a trip is urban or rural.

Urgent trips may include, but are not limited to:

1. Hospital discharge;
2. Post-surgical and/or medical follow-up specified by a healthcare provider to occur in fewer than three (3) days or seventy-two (72) hours from the procedure;
3. Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more; and
4. The results of an administrative or technical delay caused by Southeastrans and requiring that an appointment be rescheduled.
5. Mobile Crisis Requests or Crisis Stabilization Discharges
6. Same day appointments with outpatient behavioral health providers

In the event that an eligible BlueCare/TennCare Select member request transportation services to a covered service in less than the required timeframes and/or the trip does not qualify as an urgent trip based on the above definition, Southeastrans will make reasonable efforts to schedule the member’s request with a network NEMT provider, a non-network provider, or a Southeastrans shooter van if any of these resources are available to accommodate the request within the three (3) hours of the time the request is made in urban areas and four (4) hours in non-urban areas.

Members and healthcare providers who fail to request transportation services for trips that do not meet urgent care criteria less than seventy-two (72) hours before the NEMT service is needed will be reported to BlueCare/TennCare Select as a non-compliant member. BlueCare/TennCare Select will provide a notice to non-compliant members as a means to educate members concerning proper notice to request NEMT services.

**Escorts**

An escort is an individual who accompanies a member to receive TENNCARE covered services. Southeastrans shall authorize one escort to accompany a member or group of members who require assistance during the transport. Transportation providers must allow the escort to accompany the member at no charge to the member or the escort. NEMT provider trip manifests shall indicate when an escort has been approved for an assigned trip.

An individual may serve as an escort if they meet the following criteria:

1) Any person over the age of twelve (12) selected by the member;
2) Any person under the age of twelve (12) is presumed to be too young to serve as an escort unless specific facts provided by the member demonstrate to a reasonable person that the proposed escort could in fact be of assistance to the member; and

3) Any person under the age of six (6) is excluded in all cases from the role of an escort.

**TennCare Kids Transportation**

Southeastrans will schedule non-emergency transportation for routine covered medical appointments including TennCare Kids for children under the age 18, and an escort. To comply with the TennCare Kids requirements, John B. Consent Decree, and BCT requirements, transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to the member’s age or lack of an accompanying adult. Any decision to deny transportation of a minor child due to a member’s age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the “mature minor exception” to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (TCA 33-8-202, CRA Attachment XI.A.4.1.1).

If the member requires approved specialty medical services, which requires overnight or extended travel, BCT will coordinate arrangements with Southeastrans to provide transportation to the assigned healthcare provider.

TennCare Kids members under the age of 18 do not require an escort if the member is married or pregnant.

Southeastrans will contact BCT for assistance on the proper management of a TennCare Kids transportation request for an eligible member when:

- Member is under age eighteen and does not have an escort.
- Member has an escort, but escort is not a parent or legal guardian and cannot legally sign for the member to receive medical care. (*Southeastrans will ask if the escort has legal authority to sign for medical care for foster or step children when scheduling transportation services. Southeastrans will only transport members in foster care or state custody when the member has special needs.*)
- Member or escort shows one or more of the following: disorderly conduct, armed (firearms, knives or other weapons), intoxicated, possession of illegal drugs, or any other condition that may affect the safety of the driver or other passengers.

**Member Grievance Process**

BCT is responsible for receiving, investigating, and resolving all grievances from BlueCare/TennCareSelect members regarding delivery of NEMT services. This includes grievances received from members or from healthcare providers or other individuals or
groups on behalf of a BlueCare/TennCareSelect member. Southeastrans cooperates with BCT in investigating and resolving all member grievances. (See Appendix B)

**Appeals Process**

Members also have the right to appeal any decision or action by Southeastrans that adversely affects their transportation needs or their access to care. All appeal procedures are handled by BlueCare/TennCareSelect and regulated by the Division of TENNCARE. Members who are not satisfied with decisions or actions concerning their transportation service should be referred to the appropriate BlueCare/TennCareSelect Member Services Department listed below based on their MCO plan.

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<tr>
<th>Service</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>BlueCare Member Services</td>
<td>1-800-468-9698</td>
</tr>
<tr>
<td>TennCareSelect Member Services</td>
<td>1-800-263-5479</td>
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If a member requests to file an appeal or refuses to contact BlueCare/TennCareSelect for further assistance, Southeastrans will refer the member directly to the TENNCARE Solutions Unit to file an appeal.

If BlueCare/TennCareSelect is unable to resolve the issues and the member is still not satisfied with their transportation services, they will be referred to the TENNCARE Solutions Unit to file an appeal.

**TENNCARE Solutions Unit**
TENNCARE Solutions Medical Appeals
PO Box 593
Nashville TN 37202-0593
Fax: 1-888-345-5575
Phone: 1-800-878-3192

See Appendix A for additional information on member’s rights and appeals.

**Scheduling Requirements**

**Hours of Operation**

Southeastrans will ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

The NEMT Call Center will be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume.
The Southeastrans Chattanooga Call Center will be staffed Monday through Friday between the hours of 5 a.m. to 7 p.m. in the time zone applicable to the Grand Region served by Southeastrans to receive and process Member requests. Between the hours of 7 p.m. and 5 a.m. Monday through Friday, and during weekends (7 p.m. Friday through 5 a.m. Monday) and approved holidays, Southeastrans’ Dispatchers are available to respond to urgent trip requests and other after-hour issues that require immediate attention. Southeastrans’ Atlanta Call Center serves as an emergency back-up center if the Tennessee Call Center becomes inoperable due to a fire, flood, or other catastrophic event. Dispatchers in the Georgia NEMT Call Center have access to the Tennessee trip management system to schedule trips and to process urgent care transportation requests. They also have eligibility verification capabilities and immediate access to the manager on-call for the Southeastrans Tennessee Operations.

After-hours requests to schedule non-urgent trips will be received and processed by Southeastrans Dispatchers in the Tennessee Call Center or the Dispatcher will record the Member’s name and telephone number and a Southeastrans Customer Service Representative will contact the Member during normal business hours on the following day.

**Telephone Numbers:**

*For Trip Reservations:*

- BlueCare - East Region: 1-866-473-7563
- BlueCare – Middle Region: 1-866-570-9445
- BlueCare - West Region: 1-866-473-7564
- TennCareSelect - Statewide: 1-866-473-7565

*Southeastrans Tennessee Administrative Office:*

(423) 893-8282

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**Transportation Performance Standards**

1. Southeastrans has high transportation performance standards and require each NEMT provider to meet (or exceed) those standards. The required TENNCARE standards for drivers and customer service are the foundation for Southeastrans expectations. These specific standards are provided to all Transportation providers in the NEMT Provider Agreement which is reviewed and approved by TENNCARE. Southeastrans monitors all Transportation providers to ensure compliance with the required standards.

2. Southeastrans informs the NEMT provider of the scheduled pick-up time to ensure on-time arrival. Should a NEMT provider continually be a “no show” or tardy for a pick-up, Southeastrans shall issue a series of warnings to the NEMT provider in an effort to correct the problem. Repetitive instances of substandard performance may require a corrective action plan, assessment of liquidated
3. Trips are assigned to the most appropriate NEMT provider based on the member’s healthcare needs, including federally funded public transportation and the use of multi-passenger vehicles. NEMT Drivers are trained in the proper use of communications equipment to ensure that dispatchers are given real-time updates on transportation status.

4. Members must be informed of any service delay to lessen the impact on members and healthcare providers. Back-up transportation is available to provide a suitable means of transportation should the initial NEMT provider not be able to complete the transport as assigned.

5. In addition to the initial inspections prior to entering into service agreements with NEMT providers and the annual inspections as required by TENNCARE, Southeastrans Compliance Officers periodically perform field evaluations and spot vehicle inspections to assure that all transportation services are provided in a timely and safe manner and in compliance with TENNCARE requirements.

6. All transportation services must only be provided by NEMT drivers and vehicles that have been authorized by Southeastrans to provide such services. Failure to adhere to all NEMT driver and vehicle requirements shall result in immediate removal from service and appropriate corrective action including assessment of liquidated damages, suspension or reduction of trip assignments, and/or termination of NEMT Provider Agreements.

### NEMT Provider Responsibilities

#### Administrative and General Requirements

1. NEMT providers shall receive trip reservations via fax or e-mail from Southeastrans each day and confirm the receipt thereof in a form acceptable to Southeastrans for ASAP or urgent trips. NEMT providers shall accept telephone orders from Southeastrans.

2. NEMT providers shall transport members and escorts or accompanying adult as applicable in accordance with the specifications of the reservations provided by Southeastrans and the terms of the NEMT Provider Agreement. The NEMT driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person’s standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. Southeastrans will ensure that if a NEMT driver refuses to transport a member the
NEMT driver immediately notifies their dispatcher, and the dispatcher notifies Southeastrans. Southeastrans will notify BCT immediately. BCT will ensure members are given notice of appeal rights for any refused trips.

3. NEMT providers shall accept telephone requests to pick-up members at medical facilities and healthcare providers for return trips (all legs).

4. NEMT provider shall inform Southeastrans of their inability or unwillingness to schedule or complete an assignment with sufficient notice to allow Southeastrans to make alternative arrangements, and contact member’s or healthcare providers to coordinate. (Sufficient Notice is defined as no less than 24 hours.) In the event that NEMT provider does not provide sufficient notice and Southeastrans must make, as a result of the short notice, premium price alternate transportation arrangements, NEMT provider shall be responsible for any incremental charges incurred. These charges shall be deducted from amounts owed to the NEMT provider.

5. NEMT provider shall establish and maintain both a dedicated telephone line and fax line for the exclusive use by Southeastrans to contact NEMT provider. The fax line shall be equipped with a fax machine.

6. NEMT provider shall ensure that all information obtained regarding BlueCare/TennCareSelect members in connection with the CRA/ TSA be held in the strictest confidence and used only as required in the performance of NEMT provider’s obligations under the NEMT provider Agreement with Southeastrans.

**NEMT Providers and Member Confidentiality**

Southeastrans requires that NEMT providers will ensure that personal information received in the process of transporting, scheduling, follow-up, quality assurance or any other activity involved in providing services for Medicaid members will be treated as confidential information. The NEMT provider will ensure that the provider’s staff will be trained and required to treat all patient information that is obtained, recorded, viewed, heard or otherwise discovered as confidential information and will not to be communicated to anyone not involved in the active care of the patient or in the normal course of business with Southeastrans.

Specifically, NEMT provider employees will be required to adhere, but not limited to the following guidelines concerning the protection of patient information:

- Members will not be asked about their medical condition, medical history, or medical diagnosis unless such information is necessary to schedule the appropriate type of transportation.

- Any medical information that is provided to employees by a member or healthcare provider while performing NEMT transportation is to be considered
confidential information that is not communicated to anyone not involved in the transportation or care of the member.

- All records which identify member names and destinations will remain on the premises of the NEMT provider. In addition, all records will be locked when not in use, not be photocopied or otherwise retained for personal use or public distribution.

Southeastrans will require that all information as to personal facts and circumstances concerning members or potential members obtained by the NEMT provider will be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of TENNCARE or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of the NEMT Agreements.

The NEMT provider will also be required to comply with confidentiality requirements that no words will be displayed on the NEMT vehicle that implies that TENNCARE members are being transported. The name of the NEMT provider’s business will not imply that TENNCARE members are being transported.

In addition, Southeastrans will require the NEMT provider to comply with the following HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT) rules:

- As a party to their agreement with Southeastrans, the NEMT provider hereby acknowledges its designation as a covered entity under the HIPAA regulations and agrees to comply with all applicable HIPAA regulations.
- In accordance with HIPAA regulations, the NEMT provider will, at a minimum:
  - Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including but not limited to the transactions and code set, privacy, security, and identifier regulations, by their designated compliance dates. Compliance includes meeting all required transaction formats and code sets with the specified data partner situations required under the regulations;
  - Transmit/receive from/to Southeastrans, staff, providers, subcontractors, clearinghouses, BCT, and TENNCARE all transactions and code sets required by the HIPAA regulations in the appropriate standard formats as specified under the law and as directed by TENNCARE so long as TENNCARE direction does not conflict with the law;
  - Agree that if it is not in compliance with all applicable standards defined within the transactions and code sets, privacy, security and all subsequent HIPAA standards, that it will be in breach of the agreement between Southeastrans and the NEMT provider and will then take all reasonable steps to cure the breach or end the violation as applicable. Since inability to meet the transactions and code sets requirements, as well as the privacy
and security requirements can bring basic business practices between TENNCARE, BCT and Southeastrans and the NEMT provider to a halt, if for any reason the NEMT provider cannot meet the requirements of this Section, TENNCARE, BCT, and Southeastrans may terminate the NEMT Provider Agreement in accordance with Section 4.4 of the TENNCARE CRA and TSA;

○ Ensure that Protected Health Information (PHI) data exchanged between the Southeastrans, BCT, NEMT provider and TENNCARE is used only for the purposes of transporting, treatment, payment, or health care operations and health oversight and its related functions. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations shall be de-identified to protect the individual member’s PHI under the privacy act;

○ Ensure that disclosures of PHI from Southeastrans and NEMT provider to BCT and TENNCARE shall be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: transportation, treatment, payment, or health care operation; health oversight; obtaining premium bids for providing health coverage; or modifying, amending or terminating the group health plan. Disclosures to BCT and TENNCARE from Southeastrans and the NEMT provider shall be as permitted and/or required under the law;

○ Report to Southeastrans, BCT and/or TENNCARE within five (5) calendar days of becoming aware of any use or disclosure of PHI in violation of this Agreement by the NEMT provider, its officers, directors, employees, subcontractors or agents or by a third party to which the NEMT provider disclosed PHI;

○ Specify in its agreements with any agent or subcontractor that will have access to PHI that such agent or subcontractor agrees to be bound by the same restrictions, terms and conditions that apply to the NEMT provider pursuant to the TENNCARE CRA and TSA;

○ Make available to TENNCARE members the right to amend their PHI data in accordance with the federal HIPAA regulations. BCT shall also send information to members educating them of their rights and necessary steps in this regard;

○ Make a member’s PHI data accessible to TENNCARE immediately upon request by TENNCARE;

○ Make available to TENNCARE within ten (10) calendar days of notice by BCT and/or TENNCARE to Southeastrans such information as in the NEMT provider’s possession and is required for TENNCARE to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, the NEMT provider shall provide Southeastrans, BCT and/or TENNCARE with the following information:
  ▪ The date of disclosure;
  ▪ The name of the entity or person who received the HIPAA protected information, and if known, the address of such entity or person;
- A brief description of the PHI disclosed, and
- A brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure.

  o In the event that the request for an accounting of disclosures is submitted directly to Southeastrans, Southeastrans shall within two (2) business days forward such request to BCT and/or TENNCARE. It shall be TENNCARE’s responsibility to prepare and deliver any such accounting requested. Additionally, the NEMT provider shall institute an appropriate record keeping process and procedures and policies to enable the NEMT provider to comply with the requirements of this Section;

  o Make its internal policies and procedures, records and other documentation related to the use and disclosure of PHI available to the U.S. Secretary of Health and Human Services for the purposes of determining compliance with the HIPAA regulations upon request.

  o Create and adopt policies and procedures to periodically audit adherence to all HIPAA regulations, and for which the NEMT provider acknowledges and promises to perform, including but not limited to, the following obligations and actions:
    - Use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI Southeastrans creates, receives, maintains, or transmits on behalf of BCT and/or TENNCARE.
    - Agree to ensure that any agent, including a subcontractor, to whom it provides PHI that was created, received, maintained, or transmitted on behalf of BCT and/or TENNCARE agrees to use reasonable and appropriate safeguards to protect the PHI.
    - Agree to report to BCT and/or TENNCARE’s privacy officer as soon as possible but within two (2) business days any unauthorized use or disclosure of member PHI not otherwise permitted or required by HIPAA. Such immediate report shall include any security incident of which the NEMT provider becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality, or integrity of member PHI maintained by the Southeastrans. The NEMT provider shall also notify BCT and/or TENNCARE’s privacy officer within two (2) business days of any unauthorized acquisition of member PHI by an employee or otherwise authorized user of the Southeastrans or the NEMT provider’s system.

  o If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of any data or compilations derived from and allowing identification of any individual who is a subject of that PHI upon termination, cancellation, expiration or other conclusion of the Agreement, and in accordance with TENNCARE CRA and TSA. The NEMT provider shall complete such return or destruction as promptly as possible, but not later than thirty (30) days after
the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in TENNCARE CRA and TSA. The NEMT provider shall identify any PHI that cannot feasibly be returned or destroyed. Within such thirty (30) days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, including but not limited to, the provisions in TENNCARE CRA and TSA the NEMT provider shall: (1) certify on oath in writing that such return or destruction has been completed; (2) identify any PHI which can not feasibly be returned or destroyed; and (3) certify that it will only use or disclose such PHI for those purposes that make its return or destruction infeasible;

- Implement all appropriate administrative, technical and physical safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement and, including but not limited to, confidentiality requirements in 45 CFR Parts 160 and 164;
- Set up appropriate mechanisms to limit use or disclosure of PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure;
- Create and implement policies and procedures to address present and future HIPAA regulation requirements as needed to include: use and disclosure of data; de-identification of data; minimum necessity access; accounting of disclosures; patients rights to amend, access, request restrictions; and right to file a grievance;
- Provide an appropriate level of training to its staff and members regarding HIPAA related policies, procedures, member rights and penalties prior to the HIPAA implementation deadlines and at appropriate intervals thereafter;
- Track training of NEMT provider staff and maintain signed acknowledgements by staff of Southeastrans’ HIPAA policies;
- Be allowed to use and receive information from BCT and/or TENNCARE where necessary for the management and administration of the NEMT Agreement and to carry out business operations;
- Be permitted to use and disclose PHI for the NEMT provider’s own legal responsibilities;
- Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by NEMT provider employees and other persons performing work for Southeastrans to have only minimum necessary access to personally identifiable data within their organization;
- Continue to protect personally identifiable information relating to individuals who
  - are deceased;
- Be responsible for informing its members of their privacy rights in the manner specified under the regulations;
- Make available PHI in accordance with 45 CFR 164.524;
- Make available PHI for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526; and
o Obtain a third (3rd) party certification of their HIPAA transaction compliance ninety (90) calendar days before the start date of operations.

- The NEMT provider shall track all security incidents as defined by HIPAA, and, as required by TENNCARE CRA and TSA, Southeastans and the NEMT provider periodically report in summary fashion such security incidents. Southeastans and/or the NEMT provider shall notify TENNCARE’s privacy officer within two (2) business days of any security incident that would constitute a “breach of the security of the system” as defined in TENNCARE CRA, TSA and Tennessee Code Annotated (TCA) 47-18-2107.

- TENNCARE and Southeastans are “information holders” as defined in TENNCARE CRA, TSA, and TCA 47-18-2107. In the event of a breach of the security of Southeastans or the NEMT providers information system, as defined by TCA 47-18-2107, the NEMT provider and/or Southeastans shall indemnify and hold TENNCARE harmless for expenses and/or damages related to the breach. Such obligations shall include but not be limited to mailing notifications to affected members. Substitute notice to written notice, as defined by TCA 47-18-2107(e)(2) and (3), shall only be permitted with TENNCARE’s express written approval.

- In accordance with HIPAA regulations, TENNCARE shall, at a minimum, adhere to the following guidelines:
  o Make its individually identifiable health information available to members for amendment and access as specified and restricted under the federal HIPAA regulations;
  o Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;
  o Adopt a mechanism for resolving any issues of non-compliance as required by law; and
  o Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

Pick Up and Delivery Standards

Southeastans understands that on-time performance is the leading indicator of member and healthcare provider satisfaction within the NEMT Program. The importance of providing transportation services in a timely and safe manner are key points of emphasis in Southeastans Provider Orientation Training and in the NEMT Provider contracts. Southeastans will ensure that the pickup and delivery standards set forth in its agreement with BCT are met as listed below;

- Arrival on time for scheduled pickup will be standard practice. Arrival before the scheduled pick up is permitted; however, a member(s) will not be required to board the vehicle before the scheduled pick-up time, however they may board if the member(s) and driver both agree.
- Scheduled pick up times should allow for the member to arrive no less than fifteen (15) minutes prior to the scheduled appointment time. This is to allow
adequate time for the member to enter the building and complete the appointment registration prior to the appointment time.

- The NEMT driver will make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver will notify their dispatcher and NEMT provider will notify Southeastrans before departing from the pick-up location.

- NEMT providers and drivers will provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).

- The NEMT provider will make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver will notify their dispatcher and NEMT provider will notify Southeastrans before departing from the pick-up location.

- The NEMT provider will ensure that member(s) are transported to and from appointments on time. Any deviation from the scheduled time of more than ten (10) minutes is not acceptable as timely service. For return trips from an appointment, the NEMT provider will arrive at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the vehicle shall arrive within one (1) hour from the time the NEMT provider receives notice that member is ready to be picked up.

- The NEMT provider will ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

- The NEMT provider will ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.

- In multiple load situations, the NEMT provider will ensure that no member(s) is forced to remain in the vehicle more than one (1) hour longer than the average travel time for direct transport from point of pick up to destination.

- The NEMT provider will ensure the delivery of member(s) to their destinations (in accordance to the manifest) on time for their scheduled appointments.

- The NEMT provider will advise Southeastrans of any unreported Standing Order re-routes due to weather, holiday(s) or any other unforeseen event.

- Southeastrans may require NEMT providers to give the status of a vehicle, including expected arrival times and each interim pick-up and drop-off location. NEMT providers must immediately notify Southeastrans’ dispatcher of any impending delay in pick up or drop off so that all appropriate parties can be notified in advance of the delay. If Southeastrans deems it in the best interest of the member(s), Southeastrans will dispatch another vehicle to expedite the trip.

- The NEMT provider will monitor trips to ensure member(s) are delivered home in a timely manner from appointments.

- The NEMT driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person’s standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. Southeastrans will ensure that if a NEMT driver refuses to transport a member the NEMT driver immediately notifies their dispatcher, and the dispatcher notifies Southeastrans.
• The NEMT provider will ensure that in the event of an incident or accident that the NEMT driver notifies the NEMT provider immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The NEMT provider is required to immediately notify Southeastrans of any incident or accidents.

Southeastrans’ trip management software captures and compares scheduled pick-up and drop-off times with actual service delivery times as reported on the NEMT provider’s electronic claim record or Trip Reimbursement Form. Southeastrans’ mobile technology app shall be completed by NEMT Drivers at the time of service and signed by the member or a representative of the healthcare provider to assure accurate reporting. If the member and the healthcare provider refuse to sign the Trip Reimbursement Form, the NEMT Driver should document the name of the individuals who were asked to sign, but refused. All actual pick-up and drop-off times are entered into Southeastrans’ trip management software during the trip reconciliation and payment approval process.

Southeastrans’ Trip Management software generates reports on all NEMT Providers comparing scheduled and actual trip times on a daily, weekly, or monthly basis. A Pick-up and Delivery Standards Report will be submitted by the Southeastrans IT Department to BCT monthly documenting the number and percentage of pick-ups that were missed by the NET Provider, pick-ups or drop-offs that were late, drop-offs where the member missed an appointment, and the average amount of time that the pick-ups or drop-offs were late. NEMT Providers who fall below the on-time performance requirement as stipulated by TENNCARE will receive a notice from Southeastrans of substandard performance. In this notice, the NEMT Provider will be required to develop a corrective action plan outlining the steps they will take to improve their on-time performance.

Southeastrans will conduct a “coach and counsel” meeting with NEMT Providers who have repetitive substandard on-time performance problems. During this remedial training session, Southeastrans will reiterate the importance of on-time performance, assist the NEMT Provider in identifying operational problems that may be contributing to the unacceptable number of late trips, and review the provider’s corrective plan of action. If the NEMT Provider is taking appropriate action to improve on-time performance but continues to fall below the pick-up and delivery standards, Southeastrans reserves the right to reduce the NEMT Providers number of trip assignments and reassign trips to other NEMT Providers until their performance improves to an acceptable level.

NEMT Providers who do not submit acceptable corrective action plans, who fail to implement their approved corrective action plan, or who continue to have unacceptable levels of performance after “coach and counseling” may be removed from the NEMT provider network. Southeastrans may also assess liquidated damages against NEMT providers who fall below the acceptable levels of on-time performance.

**General NEMT Vehicle Requirements**
All vehicles utilized by a NEMT provider in the performance of transportation under its agreement with Southeastrans must meet the requirements listed below. Each vehicle is subject to an initial and annual inspections by Southeastrans, or BCT as well as periodic random inspections at its sole discretion. Any vehicle failing to meet any of the listed requirements, at any time, will be removed from service until repairs or replacements are made which allow the vehicle to operate in conformance and has been re-inspected and approved by Southeastrans.

The NEMT provider shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer’s safety, mechanical, operating, and maintenance standards.

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

- The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer’s approved seating capacity.
- NEMT provider shall only utilize their own leased or owned vehicles and shall not sublet or arrange for transportation under its agreement with Southeastrans from any third party.
- Each vehicle must include a vehicle information packet to be stored in the driver compartment or securely stored on or in the driver’s side visor. This packet shall include the following:
  - Vehicle registration
  - Current Insurance identification cards
  - Accident procedures and forms approved by Southeastrans.
- All vehicles shall have adequately functioning heating and air-conditioning systems.
- All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: “ALL PASSENGERS SHALL USE SEAT BELTS”. Seat belts shall be stored off the floor when not in use.
- Each vehicle shall use federally approved child safety seats in accordance with state law.
- All vehicles shall have at least two (2) seat belt extensions, unless the vehicle is a newer model that has extra-long seat belts.
- For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.
- All vehicles shall have functioning interior light(s) within the passenger compartment.
- All vehicles shall have an accurate, operating speedometer and odometer.
• All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.

• All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.

• The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.

• The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.

• All vehicles shall be smooth riding, so as not to create member discomfort.

• All vehicles shall have the NEMT provider’s business name and telephone number permanent decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.

• To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TENNCARE members are being transported. The name of the NEMT provider’s business may not imply that BlueCare/TennCareSelect members are being transported.

• The vehicle license number, NEMT business phone number, Southeastrans, and Southeastrans’ toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the grievance procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to members upon request.

• The vehicle shall have a current inspection sticker issued by Southeastrans on the outside of the passenger side rear window in the lower right corner.

• Smoking & Tobacco Products shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: “NO SMOKING or No Tobacco Products”.

• All vehicles shall be equipped with a #10 unit (at a minimum) first aid kit (weatherproof) stocked with 10 ea. antiseptic cleansing wipes, 6 ea First Aid/Burn Cream Packets, 3 ea. Sting Relief Wipes, 1 ea. Forceps, 25 ea. adhesive strips 1”x3”and gauze bandages, tape, scissors, 4 ea. latex or other impermeable gloves, 1ea. Large Wound Pad, 2 ea. Eye Pads, 1 roll Adhesive Tape ½”, 1 ea Triangular Bandage 40”, 1 ea. Cold Pack, 10 ea. Non-Aspirin Tablets, 4ea. 3”x3” gauze pad and First Aid Instructions.

• Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate member and healthcare provider addresses.
Each vehicle shall be equipped with a fully charged regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver’s compartment and be readily accessible to the driver and passenger(s).

Each vehicle shall be equipped with a “spill kit” that includes Disposable Protective Apron, Identification Tag, Disposable Clean-up Scoop and Scraper, Disposable Antimicrobial Wipes, Disposable Safety Face/Eye Shield, Liquid Spill Absorbent (Solidifier), Pair of Disposable Latex or Other Impermeable Gloves, Hazardous Waste Disposal Bag, Disinfectant/Deodorizer (Germicidal Solution and Disposal Towel.

Each vehicle shall be equipped with 3 emergency triangles.

Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal on back/rear of the vehicle that says “This Vehicle Stops at All Railroad Crossings”.

Each vehicle shall have a real-time link, telephone or two-way radio. Pagers/Texting are not acceptable as a substitute.

Each vehicle’s floor must be covered with commercial anti-skid, ribbed rubber flooring or carpeting. Ribbing in vehicles equipped to transport wheelchair members shall not interfere with wheelchair movement between the lift and the wheelchair positions.

Each vehicle that requires a step up for entry must include a retractable step or running board (installed per manufacturer’s directions) as approved by Southeastrans to aid in member boarding. The step stool shall be used to minimize ground-to-first-step heights, should have four legs with anti-skid tips, be made of sturdy metal with non-skid treat, with a height of 8.25”, a width of 15” and a depth of 14” or an equally suitable replacement. Under no circumstances shall a milk crate or similar substitute be considered a viable alternative for a step stool.

The NEMT provider shall ensure that any vehicle used to cross a state’s border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

The NEMT provider shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

**Use of Child Safety Seats**

All NEMT providers must adhere to federal, state, and local laws and regulations concerning the use of child safety seats. The NEMT provider must provide the appropriate type of child safety seat based on the guidelines listed below if the parent or
guardian does not have one available. If the appropriate child safety seat is not available, the trip cannot be completed as scheduled and the NEMT provider should immediately contact Southeastrans.

The Tennessee state law on child safety seats use (as of January 2013) is listed below:

- **Children under one (1) year of age, or any child, weighing twenty (20) pounds or less, must be secured in a child passenger restraint system in a rear facing position, meeting federal motor vehicle safety standards, in a rear seat, if available, or according to the child safety restraint system or vehicle manufacturer’s instructions. (Note: If the child safety seat has a higher rear-facing weight rating, usually 30 or 35 pounds, it may be continued to be used in a rear-facing position so long as the child's weight permits. Check the manufacturer’s instructions accompanying the child safety seat for more information.)**

- **Children age one (1) through age three (3), and weighing more than twenty (20) pounds, must be secured in a child safety seat in a forward facing position in the rear seat, if available, or according to the child safety restraint system or vehicle manufacturer’s instructions.**

- **Children age four (4) through age eight (8), and measuring less than four feet nine inches (4'9") in height, must be secured in a belt-positioning booster seat system, meeting federal motor vehicle safety standards in the rear seat, if available, or according to the child safety restraint system or vehicle manufacturer’s instructions. (Note: If the child is not between age four (4) and age eight (8), but is less than four feet nine inches (4'9") in height, he/she must still use a seat belt system meeting federal motor vehicle safety standards.)**

- **Children age nine (9) through age twelve (12), or any child through twelve (12) years of age, measuring four feet nine inches (4'9") or more in height, must be secured in a seat belt system. It is recommended that any such child be placed in the rear seat, if available. (Note: If the child is not between age nine (9) and age twelve (12), but is four feet nine inches (4'9") or more in height, he/she must still use a seat belt system meeting federal motor vehicle safety standards.)**

- **Children age thirteen (13) through age fifteen (15) must be secured by using a passenger restraint system, including safety belts, meeting federal motor vehicle safety standards.**

- **Provision is made for the transportation of children in medically prescribed modified child restraints. A copy of Doctor’s prescription is to be carried in the vehicle utilizing the modified child restraint at all times.**

- **The driver of the car is responsible for making sure that children under age sixteen (16) are properly restrained and may be charged and fined $50.00 for violation of the law. If the child’s parent or legal guardian is present in the car but not driving, the parent or legal guardian is responsible for making sure that the child is properly transported and may be fined for non-compliance.**

- **Police officers observing violations of this law are permitted to stop drivers and take enforcement action. PLEASE PROPERLY RESTRAIN CHILDREN**
Wheelchair Vehicle Requirements

All NEMT providers shall ensure that vehicles used to transport wheelchair members ("Wheelchair Vehicle") must comply with the ADA requirements in effect at the time of the vehicle’s construction, and at a minimum, meet the additional requirements listed below. Each Wheelchair Vehicle is subject to an initial and annual and periodic random inspection by Southeastrans, as well as interim inspections as required by Southeastrans or BCT at its sole discretion. Any Wheelchair Vehicle failing to meet all of the listed requirements, at any time, are subject to being removed from service until repairs or replacements are made which allow the Wheelchair Vehicle to operate in conformance with the listed requirements.

- Each wheelchair vehicle must maintain a floor-to-ceiling height clearance of at least fifty-six (56) inches in the passenger compartment.
- Each wheelchair vehicle must have an engine wheelchair lift interlock system which requires the Wheelchair Vehicle’s transmission to be placed in park and emergency brake engaged to prevent movement when the lift is deployed.
- Each wheelchair vehicle must have a hydraulically or electro-mechanically powered wheelchair lift, which is mounted so as not to impair the structural integrity of the vehicle and meets the following specifications:
  - is capable of elevating and lowering a 600-pound load and shall not cause the outer edge of the lift to sag or tilt downwards more than one inch, nor shall the platform deflection be more than three (3) degrees under a 600-pound load;
  - the lift platform is at least thirty (30) inches wide and forty-eight (48) inches long;
  - the lift platform shall not have a gap between the platform surface and the roll-off barrier greater than 5/8 of an inch. When raised, the gap between the platform and the vehicle floor shall not exceed 1/2 inch horizontally and 5/8 inch vertically;
  - the lift controls shall be operable and accessible from inside and outside the vehicle and shall be secure from accidental or unauthorized operation;
  - the lift shall be powered from the vehicle electrical system. In the event of a power failure, the lift platform shall be able to be raised/lowered manually with members and shall provide a method to slow free-fall in the event of power or component failure;
  - the lift operation shall be smooth without any jerking motion. Movement shall be less than or equal to six (6) inches per second during lift cycle and less than or equal to twelve (12) inches per second during stowage cycle;
  - when in storage in the passenger compartment, the lift platform shall not be capable of falling out of or into the vehicle, even if the power should fail;
  - all sharp edges of the lift structure which might be hazardous to members shall be padded or must be ground smooth;
the lift platform shall have a properly functioning, automatically engaged, anti-roll-off barrier, with a minimum of one inch on the outbound end, to prevent ride over;

it is preferable, but not required, that the platform, when in a stored position, not intrude into the body of the vehicle more than twelve (12) inches and shall be equipped with permanent vertical side plates to a height of at least two (2) inches above the platform surface;

the lift platform surface shall be of a non-skid expanded metal mesh or equivalent, to allow for vision through the platform; and

the lift shall be furnished with reflector tape on each side except the side adjacent to the vehicle and all step edges, thresholds and the boarding edge of lift platform;

the lift platform on vehicles must be equipped with a handrail on both sides of the lift platform for the purpose of loading or unloading ambulatory members. The handrail shall meet the following requirements:

- maximum height range 30 to 38 inches;
- knuckle clearance hand hold 1 ½ inch minimum;
- be able to withstand force of 100 pounds; and
- the handrail shall not reduce the lift platform width below thirty (30) inches.

Each wheelchair vehicle entrance door shall:

- maintain a minimum vertical clearance of 56 inches and a minimum clear door opening of 30 inches wide;
- have no lip or protrusion at the door threshold of more than 1/2 inch; and
- be equipped with straps or locking devices to hold the door open when the lift is in use.

it is preferable, but not required that the side door be the wheelchair entrance.

Each wheelchair vehicle shall have a wheelchair securement device(s) (or “tie down”) that complies with applicable ADA standards for each wheelchair position. Each restraint device shall:

- be placed as near to the accessible entrance as practical, providing clear floor area of 30 inches by 48 inches. Up to 6 inches may be under another seat if there is 9 inches height clearance from floor. All wheelchairs shall be forward facing
- be tested to meet a 30 MPH/20GM standard;
- securely restrain the wheelchair during transport from movement forward, backward, laterally and overturning movements in excess of 2 inches;
- be adjustable to accommodate all wheelbases, tires (including pneumatic) and motorized wheelchairs;
- be a lock/belt system or both and must meet ADA requirements. If a belt system is used, the cargo strap shall be retractable or stored on a mounted clasp or in a storage box when not in use. A tract mounting lock system on the floor for wheelchair securement shall be flush with the floor so as not to be an obstruction or become a tripping hazard. In all cases the straps shall be stored properly when not in use; and
provide seatbelts and shoulder harnesses that are attached to the floor or to
the sidewall of the vehicle, which shall be capable of securing both the
member and the wheelchair.

- The system utilized may accommodate scooter-type wheelchairs. However,
members utilizing these devices shall be required to dismount from the device and
be seated in a passenger seat and secured in the same manner as other members.

Invalid Vehicle and Ambulance Requirements

All NEMT providers utilizing any invalid vehicle or ambulance used to cross a state’s
border shall ensure Southeastrans that the vehicle complies with any and all applicable
federal, state (State of Tennessee and/or other state), and local requirements.

The NEMT provider shall ensure that all invalid vehicles and ambulances comply with
the vehicle requirements developed by Southeastrans, which at a minimum shall include
compliance with applicable federal, state, and local requirements and immediately
remove any vehicle from service that is out of compliance.

The NEMT provider shall ensure that, at minimum, all NEMT vehicles providing a
NEMT stretcher transport are owned and operated by an entity licensed by the Tennessee
Department of Health (DOH) to provide invalid services, have an active valid permit
issued by DOH as a ground invalid vehicle, and comply with DOH’s requirements for
ground invalid vehicles and immediately remove any vehicle from service that is out of
compliance.

The NEMT provider shall ensure that, except as otherwise permitted by State of
Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to
provide ambulance services, have an active valid ambulance permit from DOH, and
comply with DOH’s requirements for ambulances. The NEMT provider shall also ensure
that vehicles comply with any applicable local requirements and immediately remove any
vehicle from service that is out of compliance.

The NEMT provider shall at the request of Southeastrans provide documentation of listed
permits, licenses, etc.

Provisions Specific to Ambulance Services

Ambulance services licensed by the Tennessee Department of Health have alternative
requirements for meeting the TENNCARE NEMT requirements. Listed below are the
alternative requirements specific to licensed ambulance services.

1) Social Security Numbers – Ambulance services are not required to provide
SSN on the Provider Employee List unless you are requesting Southeastrans
to coordinate the criminal background check process for your employees.
Ambulance services should list their employee’s driver’s license number in lieu of the SSN.

2) **Vehicle Inspections** – Southeastrans and BCBST have agreed to accept TN Department of Health vehicle inspection documents as evidence of vehicle compliance with TENNCARE vehicle requirements. Ambulance services must submit copies of their most recent state inspection forms including mechanical inspection forms, as part of their application package. The TN DOH EMS Division shall provide copies of future ambulance vehicle inspections as they occur.

3) **Driver Age Requirements** – While TENNCARE allows NEMT Drivers to be 18 years of age, TN DOH requires all ambulance drivers to be at least 19 years of age. Since the DOH age requirement exceeds the TENNCARE age requirement, this is not considered a conflict that requires an alteration in provider requirements. Southeastrans’ age requirement is 21 for NEMT providers, but we shall review and approve any EMS employee younger than 21 on a case-by-case basis after reviewing their driving record.

4) **Driver Training Requirements** – The Division of TENNCARE requires 32 hours of driver training for all NEMT providers including ambulance services. Ambulance service personnel may submit any specialized driver training courses they have successfully completed for inclusion toward the 32-hour training requirement. Southeastrans shall review and approve all training credentials and certifications on a case-by-case basis.

5) **Vehicle Standards** – Ambulance services are not required to meet the list of items listed under the General Vehicle Standards section.

All other requirements for providing non-emergency transportation services to BlueCare/TennCareSelect members remain unchanged. These requirements were established by the Division of TENNCARE and apply to all transportation services and agencies rendering service to BlueCare/TennCareSelect members.

**Stretcher Vehicle Requirements:**

All vehicles used to transport stretcher Members (“Stretcher Vehicle”) must, at a minimum, meet the additional requirements listed below. Each stretcher vehicle is subject to an initial annual, and periodical random inspection by BROKER, as well as interim inspections as required by BROKER at its sole discretion. Any stretcher vehicle failing to meet all of the listed requirements, at any time, must be removed from service until repairs or replacements are made which allow the stretcher vehicle to operate in conformance with the listed requirements:

1) Stretcher vehicle must have at least one stretcher that is capable of supporting 400 pounds or more.
2) Each stretcher must have the capability to be lowered and raised from a height of 18 inches to a height necessary to load the stretcher into the stretcher vehicle without requiring the stretcher to be manually lifted from the ground.

3) Stretcher must be equipped with no less than three (3) safety belts.

4) Stretcher vehicle must have the necessary equipment to “lock” the stretcher securely in place while in the vehicle.

NEMT Driver Conduct Standards

The requirements listed below shall apply to all NEMT drivers of vehicles other than fixed route vehicles and ambulances.

- Drivers must be courteous, patient, and helpful to all members.
- Drivers must be neat and clean in appearance.
- No driver shall use or be under the influence of alcohol, narcotics, illegal drugs or any drugs or prescription medications that must or may impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time.
- No driver shall touch any member, except as appropriate and necessary to assist the member into or out of a facility or the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance for which the driver has been trained.
- Upon arrival at the destination, the driver shall park the vehicle so that the member does not have to cross streets to reach the entrance of the destination.
- Drivers shall visually confirm that the enrollee is inside the destination.
- Drivers must wear easily readable, official Southeastrans identification badges. If the NEMT provider has its own identification badge it must be pre-approved by the Southeastrans. If the transportation provider does not have identification badges available for its staff, Southeastrans shall issue badges to NEMT provider. The badges must be dispersed to all appropriate staff members. All badges must be worn on authorized driver’s outerwear in plain sight between the neckline and the waist.
- Drivers shall not engage in any behavior or practices that shall subject TENNCARE, BCT or Southeastrans to charges against protected groups.
- At no time shall drivers smoke, eat or consume any beverage while in the vehicle or while involved in assisting member(s) from entering or exiting the vehicle or while in the presence of any member(s).
- Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or Southeastrans.
- Cell phones are not to be used unless responding to a dispatcher call or making an emergency call.
- Drivers must provide an appropriate level of assistance to a member when requested or when necessitated by the member’s mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
- Drivers must regulate heat and air inside the vehicle during operations at a temperature suitable to the climate conditions outside for member comfort.
• Drivers must exit the vehicle to open and close vehicle doors when members enter or exit the vehicle and provide assistance as necessary to or from the main door of the place of destination, except when to do so would endanger the driver’s health and safety and that of other passengers on the van.

• Drivers must properly identify and announce their presence at the building of the specified pick-up location if a curbside pick-up location is not apparent, except when to do so would endanger the driver’s health and safety and that of the other passengers on the vehicle. Horn blowing is an acceptable method of identification and announcement when the above-mentioned circumstances are the case.

• Drivers must assist all passengers in the process of being seated; including the fastening of seatbelts and the securing of infants and children in properly installed child safety seats in accordance with state laws and regulations, and properly securing passengers in wheelchairs. Drivers must visually confirm, prior to allowing the vehicle to proceed, that all passengers, wheelchairs and wheelchair passengers are properly secured in their seats.

• Drivers will not leave an enrollee unattended at any time.

• Drivers must assist all passengers in the process of exiting the vehicle and in moving to the building access area of the passenger’s destination. Drivers shall confirm, prior to vehicle departure, that the delivered passenger is safely inside his/her destination.

• If an enrollee or other passenger’s behavior or any other condition impedes the safe operation of the vehicle, the driver will park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

• Drivers must provide verbal directions and support to all passengers. Such assistance shall also apply to the movement of wheelchairs and mobility-limited persons as they enter or exit the vehicle using the wheelchair lift. Such assistance shall include but is not limited to the proper stowing and securing of mobility aids and infant seats.

• Drivers will not be responsible for any passenger or members’ personal items left on the vehicle, however if found it must be returned to the appropriate person or organization and reported to Southeastrans.

The NEMT provider shall ensure that NEMT drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies Southeastrans if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the agreement with Southeastrans.

Southeastrans Compliance Officers will observe NEMT Providers as they render service to TENNCARE members to assure that NEMT drivers adhere to these conduct standards. Drivers will also be evaluated for compliance with conduct standards during the required annual road test. Any driver who fails to comply with the conduct standards will be issued a notice of non-compliance. Southeastrans reserves the right to require a non-compliant driver to attend a coach and counsel session conducted by Southeastrans and/or to attend remedial training. Drivers with more than 2 incidents of non-compliance or who fail to complete required remedial training will not be allowed to continue as a NEMT Driver within the Southeastrans provider network.
NEMT Driver Requirements

All drivers used in performance of services must, at a minimum, meet the qualifications listed below. Each driver’s record and qualifications are subject to an initial and annual inspection by Southeastrans, as well as interim inspections as required by TENNCARE, BCT or Southeastrans in its sole discretion. Any driver failing to meet all of the listed qualifications, at any time, shall be prohibited from providing service under the NEMT Provider Agreement.

- Drivers shall not engage in any behavior practices that shall subject TENNCARE, BCT or Southeastrans to charges against protected groups.
- Southeastrans reserves the right to disallow any driver from performing services.
- Drivers that are not U. S. citizens must provide a work visa approved by the U. S. Department of Homeland Security.
- Drivers must be at least 21 years of age and have current valid Tennessee Class D driver license with F (for hire endorsement) or commercial driver license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver’s state of residence.
- Drivers must meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.
- Drivers that cross a state’s border must comply with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.
- Personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.
- Drivers must pass a physical examination prior to providing services and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination utilized for each NEMT driver shall include an expiration date and shall be updated and submitted to BROKER prior to the expiration date. The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation’s Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers.
- Drivers must be legally licensed to operate the transportation vehicle to which he/she is assigned.
- Drivers must be trained prior to performing services (e.g. defensive driving, first aid, CPR, “spill kit” use, biohazard removal, member assistance, driver’s orientation, safety and sensitivity training). In addition, each driver shall receive continuing education annually in all of the aforementioned training. Furthermore, if the Southeastrans deems it necessary Southeastrans may require a driver(s) to be retrained.
- Southeastrans requires that the NEMT provider shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background checks are conducted for all drivers prior to providing services with Southeastrans and every five years thereafter. In addition, the NEMT provider
shall supply Southeastrans with a random national criminal background checks as requested. Results of background checks shall be maintained in the drivers’ file to allow for unscheduled file audits.

- Drivers must have no prior felony convictions for illegal substance abuse, sexual crime or a crime of violence. Drivers who have been convicted of any other felonies during the past five (5) years will drive and/or attend passengers only after satisfactory review by TENNCARE, BCT and Southeastrans. Drivers that have been convicted or found not guilty by reason of insanity of any of the disqualifying criminal offenses will not provide services under the Agreement.

- Drivers will be disqualified from performing services under this Agreement if they have been convicted of a criminal offense related to the driver’s involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106). Southeastrans will perform an initial screening prior to drivers providing services under the Agreement.

- Drivers will be disqualified from performing services under this Agreement if they are listed on any State’s Sexual Offender Registry or the equivalent registry in the state of the driver’s residence. Southeastrans will perform an initial screening to check sexual offender registries in all fifty (50) States prior to drivers providing services under the Agreement and every year, thereafter. This is in addition to the criminal background check and results shall be maintained in the drivers’ file as to allow for unscheduled file audits.

- Drivers will be disqualified from performing services under this Agreement if they have been convicted or found not guilty by reason of insanity of any of the following disqualifying criminal offenses: any crime involving illegal substance abuse, sexual crime, or crime of violence; any felony conviction within the past five (5) years; or any one of the following permanent and interim disqualifying criminal offenses:

**Permanently Disqualifying Criminal Offenses:**

A driver or driver applicant has a permanent disqualifying offense if convicted or found not guilty by reason of insanity in a civilian or military jurisdiction of any of the following felonies:

1. Espionage
2. Sedition
3. Treason
4. A crime listed in 18 U.S.C Chapter 113B-Terrorism, or a State law that is comparable.
5. A crime involving a transportation security incident
6. Improper transportation of a hazardous material under 49 U.S.C. 5124 or a State law that is comparable
7. Unlawful possession, use, sale, distribution, manufacture, purchase, receipt, transfer, shipping, transporting, import, export, storage of, or dealing in an explosive or explosive device
8. Murder
9. Violations of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961, et seq., or a State law that is comparable, where one of the predicate acts found by a jury or admitted by the defendant, consists of one of the offenses listed in 4 or 8 of this section.
10. Assault with intent to murder
11. Kidnapping or hostage taking
12. Rape or aggravated sexual abuse
13. Unlawful possession, use, sale, manufacture, purchase, distribution, receipt transfer, shipping, transporting, delivery, import, export of, or dealing in a firearm or other weapon
14. Extortion
15. Dishonesty, fraud, or misrepresentation, including identity fraud.
16. Bribery
17. Smuggling
18. Immigration violations
20. Robbery
21. Distribution of, possession with intent to distribute, or importation of a controlled substance
22. Arson
23. Conspiracy or attempt to commit the crimes in this section.

Under Want or Warrant:
Drivers or driver applicants under want or indictment in any civilian or military jurisdiction for any permanent or disqualifying felony listed above are disqualified until the want or warrant is released.

- Drivers must pass a drug and alcohol test prior to providing services under the Agreement. The drug and alcohol testing shall, at a minimum, meet the FMCSA’s alcohol and drug testing requirements for motor carriers. Drivers should be randomly selected for drug and alcohol testing with no less than 20 percent of drivers tested per calendar year and no less than 5 percent per quarter. The drivers tested shall be reported to the Division of TennCare quarterly providing the Driver’s name, Provider’s name, Social Security Number and whether the driver received a pass or fail result. Random Drug/Alcohol testing is drug/alcohol testing without advanced notice and drug testing should be equivalent to the type of drug test utilized when drivers are initially hired.

- Southeastrans requires that NEMT providers shall not utilize drivers who are known abusers of alcohol or known consumers of narcotics or prescription drugs/medications that would endanger the safety of member(s). If Southeastrans suspects a NEMT employee to be driving under the influence of alcohol, narcotics or prescription drugs/medications that would endanger the safety of member(s), Southeastrans requires that the NEMT provider immediately remove the driver from providing service. Furthermore, Southeastrans requires NEMT providers to
perform urine screening for traces of illicit drugs for all drivers involved in accidents involving a NEMT member.

- Southeastrans requires that drivers pass a driver license background check in any State where the driver has previously lived prior to providing services. This initial driver license background check shall, at a minimum, show the following:
  
  o No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;
  o No conviction for reckless driving within the previous thirty-six (36) month period;
  o No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;
  o No conviction for a felony involving the use of an automobile within the previous twelve (12) months;
  o Conviction for no more than two (2) minor moving traffic violations such as speeding, failure to stop, or improper operation of a motor vehicle within the previous thirty-six (36) months;
  o Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and
  o Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.

- The NEMT provider shall ensure Southeastrans that drivers immediately notify the NEMT provider and Southeastrans of any moving traffic violation or if a driver’s license is suspended or revoked.
- Drivers must maintain daily transportation logs (Trip Reimbursement Form) in accordance with the instructions listed on the Trip Reimbursement Form.
- All ambulance drivers and invalid vehicle drivers must comply with applicable DOH and local requirements and must prove such compliance by submitting to Southeastrans a copy of their certification as an EMT or Paramedic and any other certification or documents required by DOH.

It is the NEMT Provider’s responsibility to ensure that its drivers meet the aforementioned minimum requirements at all times, however, Southeastrans requires all NEMT Providers to submit documentation as evidence of compliance with all driver requirements. Southeastrans will maintain a file on every authorized driver with copies of all required documentation. Additionally, Southeastrans will record and monitor expiration dates for all time sensitive documents, certifications, and record requirements within our NEMT Provider database.

A report showing any driver documents or requirements with expiration dates within the next 30 days will be generated on a monthly basis. Southeastrans will give NEMT Providers written notice of any drivers needing to submit evidence of renewals of documents or other required driver standards. If the required documents are not received
by the expiration date Southeastrans will issue a 10-day cure letter with a notice of the driver’s non-compliance. If the requested documentation is not received by the due date stated in the 10-day cure letter, the driver will be disqualified within Southeastrans’ provider network and the NEMT Provider will be issued a “Cease and Desist” letter concerning the driver’s authorization to transport TennCare members.

NEMT Providers must notify Southeastrans immediately should any driver or attendant fail to meet any of these requirements at any time. NEMT Providers who consistently fail to provide proper documentation of driver requirements will be required to submit a corrective action plan stating how they will ensure that their drivers remain in compliance with TennCare driver standards and how they will ensure that all required evidence of compliance with driver standards will be submitted to Southeastrans. NEMT Providers who do not submit acceptable corrective action plans, who fail to implement their approved corrective action plan, or who continue to have unacceptable levels of performance after the corrective action plan may be removed from the NEMT provider network. Southeastrans may also assess liquidated damages against NEMT providers who fall below the acceptable levels of performance.

**NEMT Driver Training**

As BlueCare Tennessee’s (BCT’s) subcontractor for management of NEMT transportation services, Southeastrans shall require all NEMT drivers attend and pass a minimum of thirty-two (32) hours of initial driver training sessions prior to driving members *(These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law) in accordance with all TENNCARE requirements as specified in the Contractor Risk Agreement (CRA) and TennCareSelect Agreement (TSA) including, but not limited to the following topics:

- General Orientation to NEMT Services
- Customer Service, Courtesy, Sensitivity Awareness and Sexual Harassment
- Passenger Assistance Techniques Course
- Mental health and substance abuse issues;
- Title VI requirements (Civil Rights Act of 1964);
- HIPAA privacy requirements
- ADA requirements
- Driver conduct training
- Vehicle orientation and daily inspections
- Seat belt usage and child restraints
- National Safety Council of Defensive Driving Course (or approved equivalent)
- Wheelchair securement/safety
- Record keeping requirements
- Emergency procedures
- Emergency evacuation
- Handling and reporting accidents and incidents
- Basic First Aid & CPR (Southeastrans requires CPR training above the TENNCARE minimum requirement)
- Use of a “Spill Kit” and the removal of biohazards
- Infection control
- Risk management
- Communications
- Annual road tests
- Reporting member and provider fraud and abuse

Once a NEMT driver successfully completes background checks and all initial training requirements, they shall be issued a photo identification badge verifying their status as authorized drivers to perform services within the NEMT provider network. NEMT providers shall require NEMT drivers to wear their Southeastrans approved ID badges whenever they are providing transportation services to BlueCare/TennCareSelect members.

Southeastrans shall track all NEMT driver training and certification expiration dates within the Southeastrans NEMT database. Southeastrans shall notify NEMT providers and drivers of impending certification expirations and/or notice of their compliance with annual training requirements. Southeastrans shall require NEMT providers to require drivers to provide evidence of continuing education requirements as specified in the CRA and TSA. Southeastrans shall routinely offer training classes to accommodate new drivers entering the NEMT network as well as drivers needing to complete their annual minimum of fifteen (15) hours of annual training requirements.

The Southeastrans Tennessee Call Center shall include a large classroom for conducting initial and on-going driver training sessions. This facility shall therefore have the capability to conduct remedial and demand training classes in-house on short notice, if necessary to keep a NEMT provider in compliance. Additional courses, refresher modules, and remediation shall be provided annually to ensure continued quality service.

NEMT drivers failing to meet all initial or on-going training requirements shall not be allowed to operate a vehicle within the NEMT network. NEMT providers shall receive a notice from Southeastrans of any driver who fails to meet all training requirements and they shall be instructed to remove that driver from any vehicle operating within the NEMT network. If Southeastrans confirms that an unauthorized driver is operating a vehicle within the NEMT network, the NEMT provider may be assessed liquidated damages, suspended, or terminated from operating within the NEMT network. Proof of compliance of each driver requirement shall be maintained in the drivers’ file as to allow for unscheduled file audits.
NEMT Provider Performance Standards

NEMT provider agrees to comply with the following performance standards when providing services:

1. NEMT provider shall use only those vehicles that are properly registered to NEMT provider and approved for use in performing transportation services for TENNCARE members.

2. NEMT provider shall require the proper use of seatbelts and shoulder restraints by all front seat occupants, including the driver. Rear seatbelts shall be visible, available and functional for use by all rear seat occupants. NEMT provider shall make available and require the use of child safety seats for all occupants pursuant to Tennessee state requirements. Provider shall require the use of DOT approved safety for all occupants eight (8) years of age and younger.

3. NEMT provider’s drivers engaged in transportation under the NEMT Provider Agreement shall be properly trained to provide safe, courteous and reliable transportation at all times. Drivers shall possess a valid driver’s license and shall meet all applicable criteria for such license.

4. NEMT provider shall provide supportive invoice documentation that shall be retained by NEMT provider for five (5) years beyond the duration of the NEMT Provider Agreement, including any extensions, unless a legal action requires a longer retention period.

5. NEMT provider shall fully cooperate and direct unrestricted access to information with the State or any of the State’s contractors and agents, which includes, but is not limited to TENNCARE, OIG, MFCU, DOJ and the HHS OIG, and the Office of the Comptroller and any duly authorized governmental agency as well as BCT and Southeastrans to examine and/or audit trip documentation for BlueCare/TennCare Select members and shall assist in examining all requested documentation.

6. NEMT provider shall require drivers performing services on behalf of the NEMT provider under the NEMT Provider Agreement to attend driver-training seminars as required by Southeastrans.

Insurance, Licensure & Certification

The NEMT provider shall have, obtain, and maintain in good standing any Tennessee licenses, certificates and permits that are required including, but not limited to, state and/or local business licenses and ambulance service license, if applicable, prior to and during the performance of work under its agreement with Southeastrans. The NEMT provider shall agree to provide Southeastrans with certified copies of all licenses, certificates and permits necessary upon request.

Each of the insurance policies required below shall be issued by a company licensed to transact the business of insurance in the State of Tennessee by the Insurance
Commissioner for the applicable line of insurance and, unless waived or modified in writing by the State of Tennessee Insurance Commissioner, shall be an insurer with a minimum rating of A-IX with an A.M. Best Rating of “A” or better and with a financial size rating of Class IX or larger. Broker may permit Provider to provide services hereunder on a provisional basis, if Provider’s insurance policy is issued by a company rated below “A-“, but not below “B”. BROKER reserves the right to cancel this Agreement immediately, without cause or notice, so long as any of the policies required in this Agreement are provided through an insurance company with a Best Policyholders Rating of less than “A-“. Each such policy shall also contain the following provisions, or substance thereof, and made a part of the policy.

The NEMT provider shall, at a minimum, prior to the commencement of work, procure the insurance policies identified below at the NEMT providers own cost and expense and shall furnish Southeastrans with proof of coverage at least in the amounts indicated. In addition, the NEMT provider shall indemnify and hold harmless Southeastrans, BCT and the State from any liability arising out of the NEMT provider’s untimely failure in securing adequate insurance coverage as prescribed herein:

**Workers’ Compensation Insurance** policy(ies) must ensure the statutory limits established by the General Assembly of the State of Tennessee, or a minimum of $1,000,000.00 (one million) for each accident, disease, each-employee, whichever is greater.

**Commercial General Liability Policy(ies) as follows:**

- Combined Single Limits: $1,000,000 per person / $2,000,000 per occurrence
- The Commercial General Liability Policy must be on an “occurrence” basis.
- Liability for property damage in the amount of $1,000,000.00 including contents coverage for all records maintained pursuant to the NEMT Provider Agreement.
- No exclusions for sexual abuse and molestation, assault and battery or punitive damages are allowed
- In addition, the insurance certificate must include the following information:
  a. Name and address of authorized agent;
  b. Name and address of insured;
  c. Name of insurance company;
  d. Description of policies;
  e. Policy Number(s);
  f. Policy Period(s);
  g. Limits of Liability;
  h. Name and address of State Agency as certificate holder;
  i. Signature of authorized agent;
  j. Telephone number of authorized agent;
  k. Details of non-filed special policy exclusions in comments section of the Certificate of Insurance;
  l. Sixty days notice of cancellation/non-renewal; and
m. Policy notification requirements for claims (to whom, address and time limits) in comments section of the certificate of insurance.

**Commercial Automobile Liability Insurance**

The NEMT provider shall procure and maintain Commercial Automobile Liability insurance, which shall include coverage for bodily injury and property damage arising from the operation of any owned, non-owned or hired automobile. The Commercial Automobile Liability Insurance Policy shall **provide not less than $1,000,000 Combined Single Limits for each occurrence**. Policies must include coverage for “any-auto” (Symbol 1) and cannot be restricted to a schedule of vehicles. No exclusions for sexual abuse and molestation, assault and battery or punitive damages are allowed.

**Accident/Incident/Moving Violations Procedures**

The NEMT provider shall ensure that in the event of an incident or accident, the driver notifies their dispatcher or Southeastrans’ dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. If no alternative transportation is available from the NEMT provider, the driver must contact Southeastrans to arrange for alternative transportation. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

The NEMT provider will ensure that the driver immediately calls 911 to report the accident and to request an ambulance if there is any appearance or grievance of injury to passengers or driver. When the ambulance arrives anyone refusing treatment must sign a no-treatment no-transport form. Southeastrans must be notified immediately regardless of the day or time of day of any vehicle collisions involving NEMT provider vehicles transporting member(s) or any other incident resulting in fatality, injury or possible injury to member(s) or anyone else. Immediately upon becoming aware of any accident resulting in driver or passenger injury or fatality that occurs while providing services under the Agreement, Southeastrans will notify BlueCare/TennCareSelect and/or TENNCARE.

The NEMT Provider will provide a written accident report along with a post-accident drug/alcohol screen results to Southeastrans within twenty-four (24) hours of the accident and the police report with five (5) business days. The NEMT Provider will also cooperate with Southeastrans, BlueCare/TennCareSelect, and/or TENNCARE during any ensuing investigation.

Southeastrans will maintain its own internal copies of each accident report in the files of both the vehicle and the driver involved in the accident. Police reports associated with moving violations will be maintained in the file of the responsible driver.
Southeastrans will also maintain a Provider’s Report Card file which at a minimum contains a summary level review of provider issues including accidents, incidents, moving violations, and other compliance related matters. This report will be maintained by Southeastrans’ Quality/Compliance Manager to easily monitor non-compliance trends among NEMT providers.

**NEMT Provider Staff Orientation**

Southeastrans shall require NEMT providers and their staff (dispatchers, supervisors, and mechanics) successfully complete all sections of the NEMT Provider Orientation Program before they are authorized to enter into a service agreement for provision of services with Southeastrans.

Southeastrans’ Provider Orientation Program shall include but not be limited to the following topics:

- Description of the TENNCARE program;
- Covered and non-covered NEMT services, including requirement that transportation must be to a TENNCARE covered service. Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TENNCARE covered services
- Prior approval requirements;
- Vehicle requirements;
- Driver requirements;
- Protocol for encounter data elements reporting/records;
- Claims submission protocols and standards, including instructions and all information necessary for a clean claim;
- Payment policies;
- Information on members’ appeal rights;
- Enrollee rights and responsibilities;
- Policies and procedures of the grievance system; and
- Important phone numbers of all departments/staff a NEMT provider may need to reach at BCT.

BCT will make available to the NEMT provider an electronic copy of the provider manual via its website, [http://bluecare.bcbst.com/](http://bluecare.bcbst.com/). NEMT providers may contact BCT to obtain a hard copy at any time. BCT will contact Southeastrans on a quarterly basis to incorporate any needed changes to the provider manual.

In addition, Southeastrans shall require NEMT providers and their staff attends and passes a minimum of thirty-two (32) hours of initial driver training sessions and fifteen (15) hours of training per year thereafter.
NEMT Provider Manifest

Southeastrans’ standard practice is to provide the NEMT provider with a trip manifest two days before the date of service. The latest that a trip manifest will be issued to a NEMT Provider is no later than the NEMT provider’s close of business the day before the date of the scheduled NEMT service. NEMT providers have until 12:30 p.m. before the date of service to reject a scheduled trip.

Southeastrans will send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. Southeastrans will ensure that provision of the trip manifest is in compliance with HIPAA requirements. All NEMT providers are required to have a dedicated telephone line(s) available at all times for faxing purposes.

Southeastrans will ensure that the trip manifests supplied to NEMT providers will include all necessary information for the driver to perform the trip, including but not limited to:

- Number assigned by Southeastrans for approved trip;
- NEMT provider name;
- The mode of transportation;
- MCO/BHO name;
- Enrollee’s name;
- Enrollee’s age;
- Enrollee’s sex;
- Trip date;
- Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
- Origin of trip/place of pick-up (e.g., residence)
- Time of pick-up for the time zone applicable to the pick-up location (expressed in regular time using standard hour/minute formats (00:00) and a.m. or p.m. suffixes;
- Address of the pick-up, including street address, city, county, state, and zip code;
- Enrollee’s phone number(s);
- Number of riders (escorts);
- Time of appointment for the time zone applicable to the appointment location;
- Healthcare provider name;
- Address of the healthcare provider, including street address, city, county, state, and zip code;
- Healthcare provider’s phone number(s);
- Return trip times for the applicable time zone(s) and addresses, if applicable;
- Any additional stops (e.g., pharmacy);
- Any special needs of the enrollee;
- Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
- Whether enrollee has third party coverage, including Medicare; and
- Notes.
- Estimated Trip Mileage
If any trip assignments are made after a manifest has been issued, Southeastrans will contact the NEMT provider by telephone to confirm that they will accept the trip and then fax the trip add-on information to the NEMT provider.

**Claims and Payment Procedures**

Southeastrans has a streamlined process for receiving and verifying claims and for processing payments to NEMT providers. Southeastrans’ goal in processing provider payments is to provide accurate and timely payment to NEMT providers for services rendered while minimizing or eliminating the potential for billing fraud.

**General Documentation Procedures**

NEMT providers shall be required to properly document each trip and obtain appropriate signatures using approved forms, e-forms, or other approved methods of claims submission as evidence of services provided utilizing Southeastrans’ standards.

NEMT providers shall ensure that all documentation meets the following requirements:

- The NEMT provider, driver, and vehicle information is complete and accurate
- The driver and vehicle are authorized by Southeastrans
- The form or e-form is signed by the NEMT driver
- Each trip includes a valid Southeastrans trip confirmation number
- The eligible NEMT member’s name matches Southeastrans trip confirmation information
- The NEMT provider was the assigned NEMT provider for the NEMT member listed.
- The NEMT member signed the form or e-form (or if the NEMT member is unable to sign, a healthcare provider representative’s signature is present) If the member and/or the healthcare provider refuse to sign, the driver should record the name of the person refusing to sign and any reason they give for refusing to sign.
- Pick-up and drop-off times and mileages are present.
- If an Escort was present their name and relation to the member are provided NEMT provider is requesting reimbursement for the authorized mode of transport, unless a change in the mode of transportation was pre-approved by Southeastrans.
- Any required special rate documentation is attached.

NEMT trips must be properly documented at the time service is rendered using a Southeastrans’ approved claim form or electronic claims methodology. NEMT providers are required to use Southeastrans’ Trip Reimbursement forms as the approved manual process or Southeastrans’ Trip Reimbursement e-forms via computer tablets utilizing Southeastrans’ proprietary mobile technology. NEMT providers are required to use the method assigned by Southeastrans. Both methods are described below:
Trip Reimbursement e-Forms Submission Process: Submission of complete and accurate Trip Reimbursement e-Forms is of utmost importance and is a prerequisite to payment for trips as provided above.

A. Trip Reimbursement e-Forms using the Southeastrans issued mobile computer tablet, must be completed and signed at the time and location of each member pick-up and drop-off. The Member, Member representative, or health care professional must sign the e-form. The driver/attendant cannot sign for the Member. When using an electronic form, signatures are captured electronically via the touch-screen.

B. In the unlikely event the electronic device fails to function properly, the provider must notify Southeastrans and request permission to use paper claim forms until the problem with the device is resolved.

C. Trip Reimbursement e-Forms must be completed as follows:
   1. Southeastrans assigned vehicle number (SETI decal number), tag number, and vehicle identification number (VIN) (last 4 digits only);
   2. Date of service (automatically recorded by device);
   3. Driver’s name;
   4. Driver’s signature;
   5. Member’s name;
   6. Member’s signature (if able, or receiving facility);
   7. Unique trip confirmation number;
   8. Pick-up time (automatically recorded by device);
   9. Actual pick-up odometer reading;
   10. Drop-off time (automatically recorded by device);
   11. Actual drop-off odometer reading;
   12. Mode of transportation (i.e. Stretcher, Wheelchair or Ambulatory);
   13. Name of Escort and relationship to Member (if applicable); and
   14. Name of Attendant (if applicable);
   15. Trip status (i.e., transported, cancelled or No-Show).

   (And any other information the BROKER may deem necessary to collect from Provider pursuant to the direction of BCT or TENNCARE.

D. All claims must be certified by an authorized representative of the provider using Southeastrans’ claims processing web portal. This process requires the provider to verify the accuracy of claim data, and then submit the claim to Southeastrans for processing. At this point the claim is automatically time stamped as received by Southeastrans.

Denied/Disputed Claims GPS technology and automated time stamps within the mobile tablet device will be used to verify the actual time and location of the vehicle as the member is picked-up or dropped-off (per manifest). Claims for trips that are not verified as the correct location and/or time of the member pick-up or drop-off will be subject to denial of payment. NEMT providers may submit a Claims Denial/Dispute form for reconsideration of payment. The resubmittal of denied or disputed claims must be
received within ten (10) days of denial date for consideration. All requests for Denied/Disputed Claims consideration must be filed using Southeastrans’ approved Claims Denial/Dispute Form containing all required information. Payment for resolved claims will be made on the next payment cycle. Submittal of a Claims Denial/Dispute form does not guarantee payment of claim.

**Trip Reimbursement Form Instructions**

Trip Reimbursement Forms are claim forms used to appropriately document and invoice transportation services rendered by NEMT providers. Manual claim forms should only be used if the Provider has not been issued computer tablets or if the computer tablet becomes inoperable. Completed original forms should be bundled by date and submitted to Southeastrans on a weekly basis for processing provider payments. Payments for trips with illegible or incomplete information may be denied and returned to the NEMT provider for correction and resubmission. All information recorded must be true and accurate under penalty of violation of state or federal laws and regulations.

Provider Information:

Complete the top portion of each form with the following NEMT provider, driver, and vehicle information. All information must be printed using block style letters and a blue pen with permanent ink.

1) Check the appropriate box in the upper right corner to indicate which TENNCARE Region you are serving.

2) Record the name of your NEMT service.

3) Record your NEMT provider number assigned by Southeastrans.

4) Record the complete vehicle mileage at the start of the day.

5) Record the last four digits of the vehicle VIN number.

6) Record the vehicle number assigned by Southeastrans (inspection decal number).

7) Record the date of all transports listed on the form. A separate Trip Reimbursement Form must be completed for each date trips are rendered.

8) Record the Driver’s full name. If the driver of a vehicle changes during the course of a day, a new Trip Reimbursement Form must be completed for each driver.

9) The NEMT Driver should sign each form in the space provided.

Trip Information:
For each scheduled trip leg, complete the following information in the spaces provided. Up to seven trip legs can be recorded on each page. All information must be printed using block style letters and a blue pen with permanent ink.

1) Record the full name of the member being transported.

2) Record the trip confirmation number issued by Southeastrans.

3) Place a check mark in the Special Rate box if Southeastrans has authorized a special rate for the transport. Special rates for demand trips require that you submit a copy of Southeastrans’ special rate authorization. The special rate authorization must list the special rate and must list the person’s name that authorized the rate. Check the “Form Attached” box if the special rate documentation is attached to the Trip Reimbursement Form.

4) Record the actual time you arrive at the pick-up location using standard a.m. or p.m. format.

5) Record the vehicle’s odometer reading after arriving at the pick-up location.

6) Record the actual time you arrive at the drop-off location using standard a.m. or p.m. format.

7) Record the vehicle’s odometer reading when you arrive at the drop-off location.

8) Indicate the mode of transportation required by the by circling “A” for ambulatory, “W” for wheelchair, or “S” for stretcher. Circle “AM” if this an ambulance transport.

9) Enter the trip miles as listed on the trip manifest.

10) Obtain the member’s signature in the space provided. A signature must be obtained for each leg of the trip. If the member is unable to sign you must obtain the signature of a representative or the member’s healthcare provider. If the member and/or the healthcare provider refuse to sign, the driver should record the name of the person refusing to sign and any reason they give for refusing to sign.

12) If an escort is required to accompany the member, record the escort’s name and their relationship to the member in the spaces provided.

13) If the trip was unable to be completed as scheduled, indicate the status of the trip by circling “C” if the trip was canceled, or “NS” if the member was a “no-show”.
14) A comments section is provided for the driver to make any notations concerning the trip such as reason for cancellation, comments regarding no-shows, special circumstances, etc.

A copy of the Trip Reimbursement Form is included in Appendix C. An electronic copy of this form is available in an excel format. If you would like a copy of this file please e-mail your request to claims@southeastrans.com.

E-form Information

Southeastrans utilizes a proprietary mobile tracking technology solution, the NET InSight Mobile Application, to accurately document and immediately report pick-up and drop-off times and geo-coded locations for each leg of a trip. The Mobile Application captures all required trip log information in an electronic format that is immediately transmitted to Southeastrans via computer tablets. This technology provides real-time trip data to verify that members are transported to and from their medical appointments on time.

The system electronically captures the following key data elements during the delivery of transportation services:

✓ Date of service
✓ Driver’s name
✓ Driver’s signature
✓ Recipient’s full name and signature (or of the Attendant, if appropriate)
✓ Vehicle Identification Number (VIN) or other identifying number on file with the vendor;
✓ The NEMT Provider’s Name
✓ The Request Tracking Number
✓ Mode of Transportation authorized
✓ Actual pick up time in military time
✓ Actual drop off time in military time
✓ Miles driven per trip

The Daily Provider Trip Log also captures free text notes in case of trip cancellations, incomplete requests, member no-shows, or accidents and incidents. The Southeastrans NET InSight Mobile Application consists of four e-forms; Driver and Vehicle Sign-in, Passenger Pick-up Log, Passenger Drop-off Log, and Driver Sign-off.

The Driver and Vehicle Sign-in form and the Driver Sign-off form are each only used once per day, at the beginning and at the end of the driver’s shift.

The Passenger Pick-up Log and Drop-off Log forms are used throughout the day by NEMT Drivers to record actual pick-up and drop-off activities in real time. The driver should only enter trip data into the mobile application via the iPad tablet at the time and location of the pick-up and the drop-off. Data cannot be entered before or after the event has occurred. The dates and times of each transaction are automatically recorded by the
iPad when the trip information is entered. Entering this information at a time other than the actual pick-up or drop-off will inaccurately record the data. Trips with data inconsistent with manifests provided by Southeastrans may be denied payment.

Once the data is collected using the mobile application and successfully transmitted to Southeastrans, it is removed from the device and cannot be viewed again. Southeastrans requires all trip information collected using the NET InSight Mobile Application to be submitted before the driver logs out of the application at the end of a shift. Once the NEMT Driver logs out of the mobile application, a final close-out screen validates whether all trips have been successfully submitted.

**Encounter Data Elements Reporting and Records**

Southeastrans is required by BCT and TENNCARE to record and report specific encounter data elements concerning every trip rendered under the NEMT Program. Many of these data elements such as pick-up and drop-off times must be recorded by transportation vendors at the time the service is provided. NEMT providers must accurately and legibly complete all appropriate sections of the Trip Reimbursement forms based on the above instructions to comply with TENNCARE encounter data reporting and records requirements.

**Manual Claims Submission Requirements**

All completed claims must be submitted to Southeastrans at the following address:

Southeastrans, Inc.
4751 Best Road, Suite 300
Atlanta, GA 30337

NEMT providers are required to submit the original completed Trip Reimbursement Forms/e-Forms on a weekly basis to Southeastrans’ Central Business Office. Southeastrans publishes a NEMT Provider Payment Schedule quarterly which lists the date requirements for claims submissions and associated claim payment dates.

Southeastrans’ policy is to pay NEMT providers within thirty (30) days of undisputed (clean) invoice submissions. Southeastrans offers direct deposit payments to NEMT providers via wire transfer or electronic funds transfer to provide the most secure, convenient and rapid method of payment as possible.

Once all trips are properly verified and documented Southeastrans will generate and distribute payments to NEMT providers along with an itemized remittance document. Southeastrans will also document any denied payments and return to the NEMT provider with noted deficiencies or errors for the provider to correct and resubmit within thirty (30) calendar days of notification date.
NEMT providers are expected to follow Southeastrans’ Fraud and Abuse Polices set forth in the NEMT Providers Agreement. Confirmed fraudulent activity by a NEMT provider will result in restitution of fraudulent claims and/or termination of service with Southeastrans.

Southeastrans adheres to the prompt payment guidelines as required by the CRA and TSA and TCA56-32-126 including:

- NEMT providers will have one hundred twenty (120) calendar days for the date of service provided to submit a claim to Southeastrans.
- Ninety percent (90%) of clean claims for payment for services delivered to a TennCare member are paid within thirty (30) days of receipt.
- Process and if appropriate pay ninety-nine point five percent (99.5%) of all provider claims for covered services delivered to a TennCare member.
- Sending appropriate written or electronic notices when claims are partially or totally denied because the provider did not submit any required information or documentation. The notices will specifically identify what information is necessary to process and if appropriate pay the claim. When a claim is resubmitted with additional information it shall be considered a new claim for purposes of establishing the time frame for claims processing.
- If a provider agreement requires compensation to a provider on a monthly fixed fee basis that does not require submission of a claim, Southeastrans shall make the payment not later than one of the following:
  1. The time-frame specified in the provider agreement.
  2. The tenth (10th) day of the calendar month.
  3. Within 5 days of receiving the capitated payment and supporting remittance advise from BCT and or TENNCARE.

- Southeastrans will not deny provider claims on the basis of untimely filing in situations where coordination of benefits or subrogation, when the provider is pursuing payment from a third party, in a case of retroactive eligibility or when the NEMT provider could not have reasonably known which MCO the member was assigned to during the timely filing period. When third parties are involved, timely filing shall be calculated from the date the third party documented resolution of the claim. When a member is retroactively eligible, or the provider is unaware of members assigned MCO, the time frame for filing will begin on the date BCT or Southeastrans, or the NEMT provider received notification of the member eligibility.

Claims Dispute Process

If a NEMT provider wishes to dispute a denied claim, a claim payment amount, or any other factor concerning a claim processed by Southeastrans, the NEMT provider must submit the dispute in writing to the Southeastrans Reconciliation Manager. The written dispute must include the trip confirmation number(s) and the reason(s) for the dispute.
Claim disputes can be faxed, mailed, emailed, or hand delivered to Southeastrans’ Reconciliation Department in the Atlanta Office. The Reconciliation Manager will research the claim disputes and provide a written response to the NEMT provider within 14 days from the date of the dispute. If a NEMT provider is not satisfied with the response to the dispute, he/she can request a further review by the Director of Operations and/or the Chief Operations Officer.

If any dispute arises between the parties that either party has failed to perform its obligations and responsibilities under the NEMT Provider Agreement or Provider Administration Manual, then either party may initiate an Independent Review Process as set forth below.

Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve claims denied in whole or in part by Southeastrans, as provided in T.C.A. 56-32-226(b). It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-226. Sample copies of the Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the state’s website at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html or by calling the State of Tennessee at (615) 741-2677.

Payment for Fixed Route Transportation
Southeastrans will make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.

If Southeastrans cannot provide tickets/token/passes prior to the scheduled transportation, Southeastrans will arrange alternate transportation.

NEMT Provider Transportation Agreements
Southeastrans has a responsibility to develop and maintain a network of transportation provider resources so that failure of any provider to perform shall not unduly impede the ability of the system to provide NEMT services. All NEMT providers must submit and maintain evidence of compliance with all TENNCARE NEMT requirements prior to enrollment in Southeastrans’ NEMT provider network. Ambulance and Invalid Vehicle services must be certified by the Tennessee Department of Health (DOH) and must submit and maintain evidence of compliance with all DOH requirements.

Southeastrans is prohibited from establishing or maintaining service agreements with providers who have been determined to have committed TENNCARE fraud or been
terminated from the TENNCARE program. Southeastrans shall terminate a NEMT Provider Agreement when a pattern or substandard performance is identified and the provider has failed to correct the problem within a reasonable period of time. TENNCARE and/or BCT reserve the right to direct Southeastrans to terminate any NEMT Provider Agreement when TENNCARE and/or BCT determines it to be in the best interest of the State.

Southeastrans NEMT Provider Agreements include but are not limited to the following areas of NEMT services:

- Payment administration (Including no-shows, and escorts)
- Levels and mode(s) (as applicable) of transportation and dispatching.
- Trip Manifests
- Urgent Trip Requirements
- Telephone and vehicle communications systems
- Computer requirements
- Scheduling
- Pick-up and delivery standards
- Driver conduct
- Vehicle requirements
- Back-up service requirements
- Proper notification of specified events including no-shows, accidents, moving traffic violations, incidents, and out of service vehicles.
- Quality assurance
- Non-compliance with standards
- Training for NEMT providers, drivers, and staff
- Insurance requirements
- Confidentiality of information

**Use of Illegal Immigrants**

Prior to entering into an agreement with Southeastrans and semi-annual thereafter, the NEMT provider will obtain and retain a current, written attestation that the NEMT provider not knowingly utilize the services of an illegal alien to perform work relative to this agreement and will not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this agreement. Attestations obtained from the NEMT providers will be maintained by Southeastrans and made available to TENNCARE and/or BCT upon request.

For purposes of this policy, "illegal immigrant" is defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Agreement.
The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of NEMT Provider Agreement, a breach of which shall be grounds for monetary and other penalties, up to and including termination of the NEMT Provider Agreement.

Southeastrans will ensure that the NEMT provider attests, certifies, warrants, and assures that the NEMT provider will not knowingly utilize the services of an illegal immigrant in the performance of its agreement between Southeastrans and the NEMT provider and will not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Agreement. The NEMT provider will reaffirm this attestation, in writing, by submitting to Southeastrans a completed and signed copy of the document as Attachment X, hereto, semi-annually during the period of the NEMT Provider Agreement. Such attestations will be maintained by Southeastrans and made available to TENNCARE and BCT and/or state officials upon request.

Southeastrans will ensure that the NEMT provider understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this agreement.

Conflict of Interest

All officers, employees, agents, and independent contractors (NEMT providers) working on behalf of or with Southeastrans on public contracts are prohibited from establishing or maintaining relationships or engaging in activities that would or might create a conflict of interest, or the appearance of a conflict of interest, between Southeastrans and any Federal or state, county or local agency or other governmental entity under a contractual relationship with Southeastrans.

Southeastrans and its officers, employees, agents and independent contractors must maintain independence and impartiality regarding all relationships and activities associated with these public contracting entities. Therefore, all officers, employees, agents, and independent contractors working with Southeastrans must comply with the following requirements related to conflict of interest and contractor impartiality and independence.

1) No official or employee of a contracting state or Federal agency who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the contracted project shall, prior to the completion of the
contracted project, voluntarily acquire any personal interest, direct or indirect, in the proposed or executed agreements.

2) Southeastrans and its independent contractors shall not knowingly employ or contract with individuals or entities who have interest, direct or indirect, that would conflict in any material manner or degree with, or have a material adverse effect on the performance of its contracted services.

3) Southeastrans and its independent contractors will abide by all applicable state and/or Federal requirements which prohibit and regulate certain transactions between state officials and employees of state agencies throughout the contracting term.

4) All Southeastrans independent contractors must disclose any interest held by any state or Federal employee and report any relationship or interest with any state or Federal employees that would or might be perceived to impair their independence.

5) Southeastrans and its independent contractors will abide by all state and/or Federal requirements regarding the use of lobbyists and the filing of required lobbyist disclosure documents.

To assure compliance with this policy all Southeastrans staff and NEMT providers must review and sign a Conflict of Interest and Contractor Independence Disclosure Form annually as part of their agreement to provide non-emergency transportation services to Southeastrans under agreement with BlueCare Tennessee.

**Non-Discrimination Policy**

Southeastrans is committed to recruiting, hiring, developing, compensating and promoting the best-qualified individuals for positions at all levels within our organization. We will maintain our unequivocal commitment to and support of equal employment opportunity for all individuals, free from discrimination based upon gender, race, color, religion, national origin, ancestry, age, physical or mental disability, medical condition, pregnancy, sexual orientation, marital status or any other prohibited biases in accordance with any applicable, federal, state or local laws.

Southeastrans will take affirmative action to ensure that all employment practices such as advertising, recruitment, hiring, promoting, Southeastrans-sponsored training and educational assistance, transfer, layoff, return from layoff, termination, compensation and benefits and social and recreational programs are free of discrimination or harassment with regard to class categories protected by Equal Employment Opportunity laws, directives and regulations of federal, state and local governing bodies.

Every manager and supervisor is responsible for ensuring that the spirit and intent of our collective goals, such as Affirmative Action Programs and Equal Employment
Opportunity policies are achieved. Team members share the responsibility for treating co-workers and all other individuals with dignity and respect so that we may all achieve these very important goals.

Any reported offense that is in violation of this policy will be aggressively investigated and appropriate disciplinary actions will be taken if the accusation is found to be factual. This statement simply reaffirms our dedication to the principles of Equal Employment Opportunity, as well as the expectation that all team members will lend their full support to furthering our mutual success through implementation of these principles.
Appendix A

Member Rights Responsibilities and Appeals

All BlueCare/TennCareSelect members have rights concerning their interaction with Southeastrans and the NEMT services they receive. Southeastrans employees and NEMT providers should be aware of the TENNCARE member rights and should abide by those rights when serving BlueCare/TennCareSelect members.

General Rule – Southeastrans will comply with any applicable Federal and State laws that pertain to member rights and ensure that our staff and NEMT providers take those rights into account when furnishing services to BlueCare/TennCareSelect members.

i. **Dignity and Privacy** - Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

ii. **Receive Information on Available Treatment Options** - Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.

iii. **Participate in Decisions** - Each member is guaranteed the right to participate in decisions regarding his or her transportation, including the right to refuse transportation.

iv. **Free from Restraint or Seclusion** - Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

v. **Free Exercise of Rights** - Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way Southeastrans Inc.; the contracted NEMT providers or employees of Southeastrans Inc. treats the member.

Southeastrans also abides by member rights granted in the BlueCare or TennCareSelect member handbook which include the following provisions that apply to NEMT services.

- Member has the right to be treated with respect and in a dignified way
• Member has the right to privacy and the right to have transportation information treated with privacy
• Member has the right to ask for and get information about BlueCare or TennCareSelect transportation services and members’ rights and duties
• Member has the right to get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability
• Member has the right to make appeals or grievances about Southeastrans or his or her transportation service

Members have the responsibility to:

• Understand the information in the member handbook and member notices issued by the BlueCare/TennCareSelect.
• Give their Member Identification Number and other necessary information for scheduling and receiving transportation services.
• Follow all safety and conduct rules while receiving transportation services.
• Report any incident or injury that occurs during transportation to the proper local or state authorities, BlueCare/TennCareSelect, or Southeastrans.

Members also have the right to appeal any decision or action by Southeastrans that adversely affects their transportation needs or their access to care. All appeal procedures are handled by BlueCare/TennCareSelect and regulated by the Division of TENNCARE. Members who are not satisfied with decisions or actions concerning their transportation service should be referred to the appropriate BlueCare/TennCareSelect Member Services Department listed below.

BlueCare Member Services 1-800-468-9698
TennCareSelect Member Services 1-800-263-5479

If a member requests to file an appeal or refuses to contact BlueCare/TennCareSelect for further assistance, Southeastrans will refer the member directly to the TENNCARE Solutions Unit to file an appeal.

If BlueCare/TennCareSelect is unable to resolve the issues and the member is still not satisfied with their transportation services, they will be referred to the TENNCARE Solutions Unit to file an appeal:

TENNCARE Solutions Unit
TENNCARE Solutions Medical Appeals
PO Box 593
Nashville TN 37202-0593
Fax: 1-888-345-5575
Phone: 1-800-878-3192
Southeastrans will cooperate with BlueCare/TennCareSelect in the investigation of any transportation member appeal, and will provide any necessary information in order for BlueCare/TennCareSelect to provide a timely and accurate response to the member(s).

Appendix B

Quality Assurance and Grievance Management

The goal of Southeastrans’ Quality Assurance Program is to assure that Southeastrans and its network of transportation providers deliver the highest service quality possible to BlueCare/TennCareSelect members throughout our contracted transportation service regions. This plan addresses the scope of services internal to Southeastrans as well as the contractual obligations of the transportation providers.

Transportation Provider Quality Indicators

The transportation delivery system consists of all components required to transport an eligible member to and from the appropriate destination facility in an efficient, safe, and comfortable manner. While the contracted provider is responsible for the actual transportation function, Southeastrans is responsible for ensuring that the provider operates within the guidelines and requirements of local, state, and federal laws, and in compliance with the NEMT Provider Agreement.

Transportation provider performance monitoring occurs primarily through Southeastrans’ Quality/Compliance staff members conducting in-field observations of transportation providers rendering services. All service providers operating within Southeastrans network of transportation providers are observed periodically on a random, unannounced basis. Southeastrans also reserves the right to place a Quality/Compliance Officer on a transportation provider’s vehicle for extended periods of time to more effectively monitor the transportation delivery process. A report of each observation is documented and placed in the NEMT provider’s file. Any deficiencies or problems noted during observations are addressed via provider notices and/or coach and counsel sessions.

Monitoring activities shall include, but are not limited to:

- On-street observations;
- Random audits of NEMT providers;
- Accident and incident reporting;
- Statistical reporting of trips;
- Analysis of grievances;
- Driver licensure, driving record, experience and training;
- Enrollee safety;
- Enrollee assistance;
- Completion of driver trip logs;
- Driver communication with dispatcher; and
- Routine scheduled vehicle inspections and maintenance.

Table 1 lists the key transportation indicators of quality and their acceptable performance standards.

Table 1 – Transportation Key Indicators of Quality

<table>
<thead>
<tr>
<th>Area of Responsibility</th>
<th>Quality Indicator</th>
<th>Performance Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEMT Provider</td>
<td>Appropriate Level of Service</td>
<td>100% compliance</td>
</tr>
<tr>
<td></td>
<td>Initial pick-up timeliness</td>
<td>Within 10 min of scheduled pick-up</td>
</tr>
<tr>
<td></td>
<td>Drop-off timeliness</td>
<td>Within 10 min of scheduled drop-off</td>
</tr>
<tr>
<td></td>
<td>Return pick-up timeliness</td>
<td>Within 60 min of notification</td>
</tr>
<tr>
<td></td>
<td>Multi-load travel time</td>
<td>No more than 1 hour longer than direct transport</td>
</tr>
<tr>
<td></td>
<td>Vehicle standards</td>
<td>100% compliance with health &amp; safety requirements</td>
</tr>
<tr>
<td></td>
<td>Driver appearance &amp; conduct</td>
<td>100% compliance with requirements</td>
</tr>
<tr>
<td></td>
<td>Provider no-shows</td>
<td>Less than 1%</td>
</tr>
<tr>
<td></td>
<td>Grievance rate</td>
<td>Less than 0.1%</td>
</tr>
</tbody>
</table>

Grievance Resolution Management

Grievances from BlueCare/TennCareSelect members, healthcare providers, or the general public are taken very seriously and given the highest priority for investigation and resolution. Grievances may be received verbally by telephone or in person, or in writing. A member grievance is any grievance received from a BlueCare/TennCareSelect member, or from a healthcare provider on behalf of a member, concerning the approval, scheduling or delivery of their NEMT services. All member grievances are processed by BCT. Non-member grievances include grievances from NEMT Providers, medical providers, or healthcare facilities regarding the administration of the NEMT Program or the transportation of BlueCare/TennCareSelect members.

Member Grievances

All NEMT member grievances received by Southeastrans will be immediately forwarded to BCT as required in the NEMT agreement between Southeastrans and BCT. Southeastrans will cooperate with BCT in the investigation and resolution of all member grievances. Any member grievances referred to Southeastrans by BCT for investigation will managed utilizing the same procedures as stated below. Southeastrans will submit any required documentation and reports as specified by BCT to assure full and complete resolution to all member grievances.
Non-Member Grievances

Grievances received from NEMT providers or healthcare providers concerning the administration and delivery of non-emergency transportation services are received, investigated and resolved by Southeastrans. Southeastrans Quality/Compliance Manager is responsible for management of the non-member grievance process. All grievances are recorded and tracked in Southeastrans Grievance Module software. A compliant report summarizing the nature of each grievance, investigative findings, and resolutions is produced on a monthly basis and submitted to BCT.

If any dispute arises between the parties that either party has failed to perform its obligations and responsibilities under the NEMT Provider Agreement or Provider Administration Manual, then either party may initiate an Independent Review Process as set forth below.

Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve claims denied in whole or in part by Southeastrans, as provided in T.C.A. §56-32-126(b). It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-126. Sample copies of the Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the state’s Web site at be https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html or by calling the State of Tennessee at 615-741-2677.

Southeastrans’ Quality/Compliance Manager (QCM) records, tracks, and manages all grievance investigations and coordinates resolution development and follow-up. The QCM manages the grievance process utilizing the following steps:

1. All grievances are forwarded to the Quality Assurance (QA) Specialist.
2. The QA Specialist enters the grievance into a Grievance Log.
3. The QA Specialist completes a Grievance Procedure Form.
4. A copy of the Grievance Procedure Form is forwarded to the Southeastrans Manager responsible for the area involved in the grievance.
5. If the grievance involves a subcontracted transportation provider, a copy of the completed Grievance Procedure Form is faxed to the provider. (Transportation providers have 24 hours to respond in writing.)
6. The QA Specialist coordinates the investigation with the contract manager, the appropriate Southeastrans Manager, and/or the subcontractor provider and develops a recommended resolution.
7. The Southeastrans Manager and/or the transportation provider responding to the grievance submit their findings in writing to the QA Specialist.
8. The QA Specialist reviews all materials, consults with other Southeastrans personnel as necessary and develops a recommendation for grievance resolution.
9. A copy of the completed grievance investigation is forwarded to the QCM for review and approval.
10. The Quality Assurance Specialist completes a Grievance Resolution Form based on the approved resolution.
11. The completed Grievance Resolution Form is forwarded to the designated contract manager.
12. All grievance resolutions must be completed within three (3) business days.
13. A Grievance Summary Report is produced each month.

**Grievance Reporting**

Southeastrans tracks all grievances by category and by subcontracted provider for reporting and statistical analysis purposes. NEMT providers that receive excessive grievances or fail a grievance related inspection or driver monitoring procedure are issued a 10 day written “cure” notice to resolve the issues. In this notice, the NEMT Provider will be required to develop a corrective action plan outlining the steps they will take to improve their performance. The driver or vehicle found out of compliance will be immediately removed from service until the problem is corrected. Southeastrans will conduct a “coach and counsel” meeting with NEMT Providers who have repetitive substandard performance problems. NEMT Providers who do not submit acceptable corrective action plans, who fail to implement their approved corrective action plan, or who continue to have unacceptable levels of performance after “coach and counseling” may be removed from the NEMT provider network. Southeastrans may also assess liquidated damages against NEMT providers.

Grievance reporting categories include:

- Problem with driver
- Unsafe driver
- Provider did not show
- Rude staff
- Early service
- Late service
- Trip too long
- Improper wheelchair tie down
- Vehicle dirty
- Vehicle defect
- Vehicle heat or A/C problem
- Phone system problem
- Other grievance

**Fraud Monitoring**

Southeastrans utilizes a multifaceted approach to internal monitoring of fraud. The critical objectives are to:
- Prevent and detect fraudulent and erroneous billings and payments to providers and subcontractors.
- To conduct timely and accurate payment to providers
- Prevent, detect, review and report member fraud

Review of historical utilization patterns of our billing, payment, and trip assignment systems is a critical element to fraud monitoring. The Quality/Compliance staff conducts random spot inspections with service providers at pick up and drop off sites. We audit standing orders to ensure equal distribution of trips and problematic no-show provider payouts. We review and monitor our Public Transit Bus pass program to ensure members receive and use their passes.

Southeastrans Quality/Compliance staff conducts on-going detection methods such as spot checks, record reviews, random claim audit reviews, trip verification, member surveys, and examination of utilization trends to monitor member, healthcare provider or NEMT provider. Table 2 lists different types of fraud that our compliance staff monitors:

**Table 2 – NEMT Fraud Activities**

<table>
<thead>
<tr>
<th>Member</th>
<th>NEMT Provider</th>
<th>Healthcare Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falsifying eligibility</td>
<td>Duplicate billing</td>
<td>Giving false information</td>
</tr>
<tr>
<td>Kickbacks</td>
<td>Falsifying invoices</td>
<td>Misrepresenting member need</td>
</tr>
<tr>
<td>Misrepresenting need</td>
<td>Billing round trip on one-way trip</td>
<td></td>
</tr>
<tr>
<td>Card loaning (public transit)</td>
<td>Misrepresenting need</td>
<td></td>
</tr>
<tr>
<td>Misrepresenting access</td>
<td>Non-covered destination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Misconduct by agency staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falsifying cost reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falsifying records</td>
<td></td>
</tr>
</tbody>
</table>

**Transportation Provider Corrective Actions**

Southeastrans Quality/Compliance staff conduct scheduled and random, unannounced vehicle inspections. Each inspection is documented on Southeastrans’ Vehicle Inspection Form (see Appendix D) and all deficiencies or areas of concern are properly noted. Deficient NEMT providers are given a period of ten (10) days to “cure” or bring their vehicle(s) up to standard. During this time the vehicle will be removed from providing service for BlueCare/TennCareSelect members. A re-inspection is then performed to confirm compliance with those recommendations. Repeat offenders receive a “cease and desist” letter stating that if corrections are not made, the provider shall be terminated from Southeastrans network. All incidents and/or grievances are documented and become a permanent part of their provider record. Transportation providers must meet all requirements of the CRA and TSA.
Southeastrans Trip Management software produces On-Time Performance reports for various service periods to measure compliance with pick-up and delivery standards. Southeastrans conducts quarterly meetings with NEMT providers to discuss contract issues, performance, and other network issues.

**Non-Compliant NEMT Providers**

Southeastrans will ensure that its NEMT providers are qualified to perform their duties as specified in Southeastrans’ NEMT Provider Agreement. This includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Southeastrans has policies and procedures to address what actions are to be taken if a NEMT provider is found non-compliant in its ability to perform their duties as a Southeastrans NEMT provider. This includes up to immediately removing the NEMT provider from service to perform NEMT. Individual NEMT drivers and/or NEMT vehicles will be removed from service for any failure to comply with all NEMT requirements. All compliance deficiencies must be corrected and appropriately documented in the NEMT provider file prior to reinstatement within the network.

All NEMT provider inspections and other monitoring activities including driver credentialing checks, vehicle inspections will be documented in the NEMT provider’s permanent file. Any deficiencies or instances of non-compliance will be documented along with follow-up actions, associated corrective action plans, assessment of liquidated damages, and final resolutions. All monitoring activities, monitoring findings, corrective actions, and resulting improvements will be submitted in an annual NEMT Provider Monitoring Report.
Appendix C

Trip Reimbursement

A copy of the current Trip Reimbursement form is available at the following link:

Appendix D

Vehicle Inspection

Copies of the current vehicle inspection forms are available at the following links:


Appendix E

Passenger Assistance & Sensitivity Skills Training Program

January 2013
Wheelchair Lifts

Wheelchair lifts make it possible to load chairs of all weights in an efficient and safe manner. However, a lift can be a potentially dangerous piece of equipment and must be maintained and operated properly. Though the driver’s loading job is made easier, there is a great deal of caution and awareness needed when operating a lift. No one should operate the vehicle’s lift but the authorized driver or other properly trained NEMT employee. As with other adaptive equipment, lifts may differ slightly in structure and operation; each driver should be familiar with all the lifts he or she could be expected to use.

Positioning – Hydraulic lifts may be located at the rear or center of the van. The driver soon gets the feel for positioning the van so that the platform falls over a specific spot. One problem with lift positioning occurs when a parallel walk runs too close to a curb. When your platform is lowered, the end overshoots the center of the walk. This means that the chair must be rolled over the grass on the far side to get onto the lift platform. To avoid this, position the van slightly farther out from the curb remembering not to create too big a step to the curb for the ambulatory members using the service door. Ensure the loading spot is free of obstacles and follow these steps:

1. Keep the engine running because the lift requires a lot of power;
2. Turn on the four-way flashers;
3. Set the parking (or emergency) break;
4. Turn off other accessories while operating the lift (i.e. air conditioning);
5. Unlock the door from the outside and secure both doors in the open position being careful to not let them swing freely.

Operating the Lift Controls – Controls for the lift should be situated so as to be used by the driver only. They should be permanently mounted near the lift so that the driver can use them with loading solo or with the help of an assistant. On most control boxes, one lever operates the FOLD function of the platform, taking it from vertical or horizontal. Another lever or a set of two buttons takes the platform DOWN to the ground level or UP to the floor level. A light touch on the levers is all that is needed. Rough treatment may result in damaged electrical connections and a breakdown.

Loading on a Platform Lift

1. Communicate with member throughout the loading and securement process;
2. Lower the platform to the ground level;
3. Let the platform drop far enough for the end-retaining flap to unfold flat;
4. Release the control button before the lift rams “jack” up the van (many lifts have cut-off switches, though, to prevent jacking);
5. Keep your feet and others out from under the platform;

6. Pre-inspect the member’s wheelchair that is safe and is in good working order

7. Back the wheelchair to the end of the platform and pull it up and on carefully. The front casters MUST be totally on the platform. The driver’s heels must be within the back edge of the platform. The area within the wheelchair’s handles creates a good place for you to stand;

8. Brake both wheels

9. Grasp one wheelchair handgrip with one hand. Operate the UP bottom of the control box with the other hand;

10. Raise the lift to floor level. As the lift leaves the ground, be sure the retaining flap on the end flips up into place;

11. At floor level, always keep one hand on the chair while reaching around to release the brakes, one at a time;

12. Pull the wheelchair back into the van watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance.

Unloading on a Platform Lift

1. Open and secure lift doors from the outside. Unfold the lift.

2. Re-enter the van through the service door. Do not jump up onto the lift!

3. Push the wheelchair slowly forward out onto the platform at the same time watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance.

4. Be sure to center the chair as you go.

5. Lock one brake and then the other, always holding onto the chair with one hand. CAUTION: If the van is sitting so that it is slightly tilted to one side, then the platform will also be tilted downward. There will be an added pull on the chair as you are setting the brakes. Be sure you have a firm grip. This is also the main reason that chair’s brakes must be able to hold the chair and that the end-retaining flap must operate correctly.

6. With one hand on the handgrip, lower the platform with the other hand on the controls.

7. At ground level, unlock the wheels and push the chair off the platform.

NOTE: The driver must stand behind the wheelchair after pulling it onto the lift and remain standing on the lift until it stops at floor level. No member will ever be raised on the lift without the driver standing behind and holding the chair with one hand. This is for both your and the member’s safety and well being.

Loading on a Platform Lift with Assistance

1. Open the lift doors, secure both of them it, unfold the lift and lower it to ground level.
2. Pull the wheelchair onto the platform, at the same time watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance.

3. Lock both wheels and step off of the lift.

4. Grasp a section of the chair’s frame with one hand and operate the controls with the other hand.

5. Raise the chair to the floor level.

6. As the platform approaches the floor level, the assistant should grasp the wheelchair’s handgrips.

7. While the assistant holds the wheelchair in place from the floor level, the driver should walk to the front of the platform, keeping a hand on the wheelchair at all times.

8. Facing the chair, the driver then releases the brakes, one at a time, while holding the chair place.

9. As the assistant pulls the chair into the van, at the same time watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance, the driver assists by pushing and guiding from the front.

10. The assistant positions the chair in the vehicle and the driver will lock it down.

THE DRIVER OR THE ASSISTANT MUST ALWAYS HAVE AT LEAST ONE HAND ON THE WHEELCHAIR AT ALL TIMES WHILE IT IS ON THE PLATFORM.

Unloading on a Platform Lift with Assistance

1. Open the lift doors, secure the doors and unfold the lift.

2. The assistant should slowly push the chair out onto the platform, at the same time watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance, while the driver assists by guiding the chair and stopping it in the proper position.

3. As the assistant holds the chair in position, the driver should set both brakes.

4. The driver should then move to the side of the lift, keeping one hand on the chair.

5. Give a verbal cue to the member and lower the lift. The assistant should release the handles as the chair lowers out of reach.

6. When the lift reaches ground level, the driver should release the chair’s brakes and roll it off the platform.

Loading Power Chairs on Platform Lifts – Caution is needed when loading a power chair on a platform. If the chair’s power is left on, there is a potential for the chair to move while on the platform, even while the brakes are applied. The extent of movement could cause personal injury. Many of the people operating these chairs are slow to react or may
have involuntary movements. Their arms may hit the control stick. It is, therefore, recommended that the power sources be disengaged during loading operations.

Steps to Load a Power Chair on a Platform Lift

1. Back the chair onto the platform and turn the toggle switch on the control box to the OFF position (or ask the assistant to do so).

2. Disengage the drive belts from the pulleys by moving both clutch levers forward. Power chairs should not be moved without their power unless both belts are disengaged.

3. Set the brakes and raise the chair.

4. Pull the chair off the platform manually into the van, at the same time watching your head and that of the member because the overhead clearance is low. In addition to watching the legs and arms for clearance, a guiding push from the driver outside the van is recommended. Remember...you are now dealing with a heavier chair.

5. Once totally inside the van, you should move to the front of the chair and push in backwards into the desired position.

6. Do not engage the belts or turn the power on again until the chair and the lift’s platform are back on the ground after unloading.

Lifts on Vans – Some different considerations must be made when operating a lift installed in a van:

- You will generally not have an assistant with you on the van. All loading will be done solo.

- On many vans the roofline and door threshold will be much lower. After pulling the chair onto the lift and locking it down, you may need to step up into the van in a crouched position while raising the lift and holding the chair.

- Because of a low overhead threshold, you may need to have your passenger bend their head to enter and exit. You may need to position your hand on the passenger’s head to gently ease it under.

- Never tilt a wheelchair on the lift to get a high back under a low doorway. This is a very dangerous maneuver. Such wheelchairs should be in high-topped vans.

- It is critical to lock both brakes on a van lift.

Manual Operation of the Lift – Since power lifts occasionally break down, it is important to know how to operate the lift manually. Before performing the manual operation of the lift, communicate your problem with your dispatcher. Follow the manufacturer’s instructions for proper operational procedures. If these are unclear, contact your dispatcher for assistance. Upon you return to your office, make sure your van is sent to maintenance immediately for repair.
Securing Systems

Care should be taken to secure objects in a van so that the potential for causing injury to a member/driver is reduced. Wheelchairs should be secured by the appropriate mechanisms. Ambulatory members should be seated and their seatbelts secured in place. Heavy, loose objects should be stored or otherwise secured to the extent that the driver is reasonably able to do so.

There are two main types of wheelchair securing systems:

1. The **four-point tie down** (strap and track) system allows flexibility in the types of chairs that can be secured. When fully attached, all corners or sides of the chair will be firmly secured to the floor.

Seat Belts – In special transportation vans, the general motion of the vehicle may affect certain passengers. Therefore:

- Drivers should wear a seatbelt **AT ALL TIMES**, even between stops that are close together and/or where you must leave your seat repeatedly. There is never an excuse for not wearing your seatbelt. Also, it’s the law.
- All passengers must wear Seatbelts at all times.

Securing Wheelchairs – Wheelchairs and their occupants must be secured in three ways before the vehicle is moved. These are referred to as The Three B’s:

1. **SECUREMENT DEVICES:** The securement devices must be in place. This is one of the most critically important procedures in transporting wheelchairs. The securing system is only as good as the thoroughness of the driver or assistant who does the securing. Check and recheck your wheelchair-securing devices **before** moving your vehicle.

2. **BRAKES:** The brakes on the wheelchair must be locked down. Even when the wheelchair is bracketed to the van, there may still be slight play in the wheels. The locks on the chair will keep the wheels firmly positioned. Efficient brakes are needed when the wheelchair is on the lift. Report loose and ineffective brakes to your member and dispatcher.

3. **BELTS:** The belt attached to the inside of the wheelchair must be buckled. It does absolutely no good to secure a wheelchair to the van if the passenger is not secured to the wheelchair. This must be a bona fide seatbelt with a clasp or buckle. As stated above, Velcro-type fasteners do not make satisfactory seatbelts for transportation purposes. Some vehicles may have seatbelts attached to the vehicle. Be sure the belt crosses the wheelchair user only at the lower waist or lap level.
The first thing to consider about a wheelchair is its great importance to its owner. This chair is as valuable to him/her as the body part or function that it has now replaced. Whatever the disability, the wheelchair provides mobility and mobility increases the opportunity to get the most out of life.

There has been considerable growth and diversification from what once was the “standard” or “manual” wheelchair. Though the manual chair still predominates, many other models are being transported. The industry is become more sophisticated and is building chairs that are modified for the specific support and propulsion needs of the individual.

Specialized transit drivers may encounter electric or power chairs, power carts, travel chairs or even “growth” chairs, like the Mulholland, for children. The structure and securing requirements of each chair needs to be addressed.

**Manual Wheelchair** – The standard, manual wheelchair is used when an individual has good head and trunk support. Some of the components of the standard chair include:

1. Hand grips
2. Vinyl back and seat
3. Armrests
4. Footrests
5. Casters
6. Hand rim
7. Tilt bar
8. Brake lever

**Modifications and Accessories** – Modifications and accessories for manual wheelchairs are common, depending, again, upon the needs of the individual. Some of the more prevalent variations you may see include:

- **Extended backs:** For upper body and neck support
- **Brake lever extensions:** For those unable to reach the standard brake levers.
- **Removable footrests:** The lever behind the footrest releases the support. (Always consult healthcare provider personnel before removing footrests for any reason.)
- **Work tray:** Constructed of wood or Plexiglas and attached to the top of the armrests. Provides a working and eating surface.
- **Communication board:** An alphabet, word or symbol chart attached to the work tray. The child with a verbal impairment points to appropriate letters and words to give a message.
- **Autocom:** One of many types of electronic communication boards. The member uses a magnetic “wand” to spell messages that are then displayed on a small screen.
- **Reclining back**: The wheelchair’s back tilts to an angle better suited to the member’s postural needs.

- **Pneumatic tires**: Air-filled tires (instead of hard rubber) which give a smoother, bump-absorbing ride.

- **Sports chair**: Lightweight tubing construction that lends flexibility and responsiveness for sports events and general purposes. Wheels may be cantilevered at the bottom.

**Electric or Power Chair** – The motorized wheelchair has become an invaluable machine for many in the disabled community. While they may be physically unable to wheel themselves around in a manual chair, they are able to steer a power chair with a slight hand movement on a control lever. Those who have sufficient motor skills and perceptual abilities learn to safely steer their power chairs to any accessible location.

The power chair is not a complicated machine, however, because of its independent power source, its weight (between 100 and 200 pounds) and its costs (starting at $3,000), it is important that drivers and assistants dealing with power chairs become familiar with their operation.

Some of the mechanical and electronic parts on the power chair include:

1. Control box
2. Right motor
3. Pulled and belt
4. Circuit box
5. Clutch lever

The power chair operates on batteries housed behind the chair. The batteries power two small motors, one under each side of the chair’s seat. Each motor drives a pulley and belt that turns the rear wheel. The drive belts can be disengaged from the pulleys by moving the clutch handles on either side of the chair forward. (Belts must be disengaged whenever the chair is moved around without its own power!) This whole system is directed from the control box at the occupant’s fingertips. This may be installed on the right or left side of the chair. The toggle switch behind the box has three positions: HI, OFF, LO. The control stick on top of the box controls both direction and speed. The stick may be pushed in any direction. The chair will respond in that direction. The further down the stick is pushed, the faster the chair will drive. It requires a great deal of skill to maneuver the chair accurately and steadily using this single stick with dual-control functions.

The two bars with rollers extending out behind the rear of the chair prevent the chair from tipping backward. These are nicknamed “wheelie bars.” The bars curve downward and may, at times, hit a ramp or lift surface when loading. Both bars may be twisted upward to temporarily get them out of the way. A spring-loaded button beneath each bar must be pushed in to release and turn the bar. Always return the bars to the downward position after unloading the chair. (Do not take the bars off. They may get damaged or lost.)

The Travel Chair – The collapsible Travel Chair is used with young children who have poor head and body control. It resembles a child’s stroller. Brakes consist of a bar that is forced onto the rubber of the rear tires. Brake set and release levers are operated by foot.
To Collapse the Travel Chair

1. Place one foot on the horizontal bar at the bottom of the frame.
2. Place your right hand on the handle so that you are grasping the release lever under the handle.
3. Squeeze the handle lever at the same time you push downward on the frame with your foot. This will disengage the positioning pin.
4. When the positioning pin has been released, you can then gently lower the back of the chair down to the reclined position. There is also a middle position between the upright and reclined positions.

The Growth (Pediatric) Chair – The growth chair is a multi-adjustable chair used for support for those who have poor head and trunk control. The pads and supports help keep the member in the correct postural position.

Brakes are set and released with a foot-operated lever on a brake bar behind the chair. An adjustable rod is forced onto the tire to brake the chair. (This brake may not be fully effective.)

The Amigo – Semi-ambulatory people who may be able to walk only short distances often use the Amigo chair. Its popularity has increased over the past ten years because of its flexibility and cost. A small battery-operated motor powers the chair. This chair enables them to travel longer distances over relatively smooth surface. It is ideal for use inside the home, in shopping malls and at large theme parks.

Because of its small wheels and high center of gravity, the Amigo is not well suited for travel over rough surfaces or for transport on specialized transit vehicles. The design and structure of the chair is such that securing of the passenger and chair cannot be done safely on almost all vehicles.
ASSISTANCE TECHNIQUES

Movement – Proper handling techniques ensure safety and comfort for the occupant. Just as you would assist an ambulatory person slowly and carefully, so you should move a person in a wheelchair. Learn to make your movements smooth and gentle. Do not jerk or jolt as this can be very uncomfortable, or painful, for the person in the chair.

When moving a person in a wheelchair you must be confident of your ability to be in control and be able to relay this confidence to your passenger. The passenger is often put in vulnerable situations, as when sitting on a ramp or lift. There is total dependence on your firm but gentle control. There is great psychological benefit from having the passenger know you are in control and that they can trust you.

You should prepare your passenger for movement by telling him/her when you are going to start moving. A simple verbal cue like “Here we go!” or “Are you ready?” will prepare your passenger for your next move. This is especially needed when tilting a chair or as you start your lift up and down. Most people in wheelchairs are used to being tilted and do not startle easily. However, you never know when your next member may be new to a wheelchair. Never assume!

Checking the Chair – A wheelchair is very valuable to its occupant so it is important to treat it carefully. Be careful not to scratch the tubing on corners of lifts when in the vehicle. The vehicle securing brackets should not gouge the inner rims of the wheels.

Center of Gravity – Transporting people in wheelchairs involves a few basic handling maneuvers that, when done properly, can move the wheelchair around efficiently and easily. Just getting the feel for pushing a wheelchair around on the level surface is the first step in becoming accustomed to its movement.

As you push the chair around, you can feel that the weight is distributed fairly evenly between the front and rear wheels. The center of gravity in an unoccupied chair is just above and forward of the rear axle.

The center of gravity is raised, however, when the chair is occupied and it moves to the top of the armrests. Therefore, thought weight is well distributed, the chair’s short wheelbase and high center of gravity makes it possible to spill a person forward. Hitting a crack in the sidewalk or on the base lip of the lift with the front wheels may be enough to cause such a spill.

Handling Techniques – In all handling cases, be sure you grip the wheelchair firmly. Use good body mechanics to keep your back straight, bending at the knees and leaning your body into the chair to increase control. Be sure of your footing, especially on wet or icy surfaces.

Important Things to Remember NOT to do:

- DO NOT wear shoes that may come loose or cause you to trip or turn your ankle.
- DO NOT lift a wheelchair by its wheels. The chair could spin and tip on its back!
• DO NOT lift a chair by its armrest. They may be removable and come loose.

• DO NOT release a wheelchair from your grasp until the brakes are set. Even then, be wary of the brakes’ capacity to hold, especially on a grade.

Tilting – Tilting a wheelchair back on its rear wheels can make it easier to maneuver. This is also a preliminary move in getting a chair up onto a curb. Before tilting the chair, be sure the occupant’s feet are securely on the footrests and their arms and fingers are free of the wheel’s spokes. Also be sure there is enough room to maneuver once the chair is tilted.

**To Tilt a Wheelchair**

1. Give a verbal cue indicating that you will be moving the member.
2. Place one foot on the tilt lever extension and grasp both handgrips firmly.
3. Push down the tilt lever extension with your foot while pulling back and down on the handgrips.
4. Rotate the chair back on the axles of the rear wheels to the “balance point.”
5. Maneuver the balanced chair by pivoting the rear wheels.

**To Return the Wheelchair to its Horizontal Position**

1. Place your foot on the tilt lever extension.
2. Lean into the tilt lever as you lower the chair to its horizontal position. Lower the chair carefully and smoothly so as not to jar the passenger when the front casters touch the ground.

Curbs – Getting a wheelchair up and down a curb is much easier than it appears. Half of this maneuver simply involves tilting the chair.

**Going Up a Curb**

1. When approaching a curb, stop a little before the footrests reach the curb’s edge.
2. Tilt the chair into the balance position.
3. Move the chair forward until both rear wheels butt up against the curb.
4. Lower the front wheels onto the curb surface.
5. Place one foot forward, bend knees slightly and roll the rear wheel onto the curb.
6. With a straight back, pull up and lean forward. The wheels will roll up and over the lip of the curb. Do not try to pick the rear wheels up off the surface.

**Going Down a Curb**

1. Taking a chair down a curb is simply the reverse of taking it up. When approaching the topside of the curb, pivot the chair around so that it goes down back first. You are in much greater control being behind and below the chair and less likely to injure your back.
2. Back the wheels of the chair to the edge of the curb.
3. Plant both feet on the lower level of the curb about 18” from the bottom of the curb.

4. With a straight back, lean into the chair as you pull it over the edge of the curb and ease the wheels to the ground.

5. Tilt the chair to the balance position.

6. Pull the chair away from the curb until you are sure the footrests will clear.

7. Ease the front casters to the ground.
ASSISTING AMBULATORY MEMBERS

Many people not confined to wheelchairs also need your assistance on the vehicle. The vision-impaired may need guidance to their seats and those with mobility impairments may have difficulty walking. Those with cerebral palsy may have balance problems and the elderly may not only have balance problems but also high anxiety about falling.

Drivers need to be alert to situations that might require their assistance. Below are some guidelines for assisting the ambulatory.

Going Up and Down Steps

- When assisting someone on steps position yourself below the person to put you in a better position to assist them if they stumble or fall.
- Encourage the passenger to use the handrails. Be ready to assist but give the member a chance to negotiate the steps themselves.
- If a member falls or collapses toward you while being assisted on a level surface, brace yourself by setting one foot behind the other in case they need to be eased to the floor.
- Should someone fall or collapse in a direction away from you, simply ease them to the floor going with the motion of the fall but breaking the impact.
- Keep one arm around the lower back of the person and the other hand on the near elbow to help steady the walk.
Neuromuscular conditions resulting in motor dysfunction can be caused by disease, brain damage or accidents. People with a motor dysfunction may have any or all of the following:

- Difficulty with physical movement or control.
- Paralyzed - unable to move some parts of their body.
- Uncontrollable twitching or other movements.
- Restricted body movement.
- Lack of coordination/awkwardness.
- Speech impairments
- Mentally challenged

Some of the most common neuromuscular conditions drivers are likely to see include:

- Spinal injuries
- Cerebral palsy
- Multiple sclerosis
- Muscular dystrophy

**Cerebral Palsy**

More than half of the people with cerebral palsy (CP) have problems with movement, including:

- Stiffness
- Tense, contracted muscles
- Jerky, uncontrolled movements
- Unpredictable lurching movements

People with CP may have a decreased sense of balance and experience problems in communicating.

**Multiple Sclerosis**

Multiple Sclerosis (MS) is a chronic degenerative disease of the central nervous system. People with MS may have very different extremes in symptoms that can change continuously

**Muscular Dystrophy**

Muscular dystrophy (MD) is an inherited disease that causes increasing weakness in the muscles. People with MD often experience:

- difficulty walking
- speech problems
- poor vision
Seizure Disorders

Seizures are a brain disorder that can result in seizures of varying degrees of seriousness.

Types of Seizures

Minor Seizures (Petit-Mal or Non-Convulsive) - There are three types of minor seizures:

1. **Absence Seizure** - This is hard to identify because it happens so quickly. It usually lasts just a few seconds and can happen up to 100 times a day. Symptoms of an absence seizure include:
   - Staring into space
   - Rapid eye movements
   - Eyes rolling back into the head

2. **Simple Partial Seizure** - In this type of seizure, the person is conscious of what is happening and can tell you that they are having a seizure. This type of seizure can last anywhere from a few seconds up to two minutes. Some of the symptoms of a partial seizure include:
   - Tremors or trembling along one side of the body
   - Sensory distortions
   - Hallucinations

3. **Complex Partial Seizure** - In a complex partial seizure, the person’s consciousness is impaired for anywhere from two to ten minutes. While not as frightening as a major, convulsive seizure, this type can be disturbing because its symptoms include inappropriate behaviors such as:
   - Aimless walking
   - Pulling at clothes
   - Smacking lips

These symptoms can be followed by a period of confusion, indicating that there has been a seizure.

**Note:** Petit-Mal (minor) Seizures often come in a series and can be a warning that a Grand Mal (major) seizure is about to occur.

Major Seizures (Grand Mal, Convulsive or Tonic/Colonic) – This type of seizure is the most frightening to witness and the one that calls for the greatest management skills. The person having the seizure is experiencing up to 80 times the normal electrical activity in their brain and can have up to 10 times their normal strength during the seizure. There are three stages to a major seizure:

1. **Rigid** – The body becomes rigid and the person loses consciousness;
2. **Shaking** - The body shakes and convulses; and
3. **Disoriented** - The person regains consciousness but is confused and disoriented
Note: Not every person goes through every stage of a major seizure. They can have just the colonic stage or just the tonic stage. They can also produce excess saliva, lose bowel or bladder control and/or turn bluish in color.

In a convulsive seizure, a person may also make involuntary movements, lose their balance and fall, speak in a garbled, mixed-up manner, seem confused and/or experience weakness and tiredness when the seizure is over.

Seizure Do’s and Don’ts (On the Vehicle)

DO

1. Remain calm, both for your sake and that of your other passengers;
2. Pull your vehicle over and stop it safely;
3. Call the dispatch center or 911 for emergency assistance;
4. Keep the person in their securements and seat
5. Tell your other passengers what is happening and reassure them.
6. Clear the area around the person.
7. Try to time the seizure. This can be a diagnostic help if medical personnel are called.
8. Let the seizure run its course.

DON’T

1. Put anything in the person’s mouth;
2. Try to restrain the person in any way.
3. Loosen the seatbelt.

It is important to use Common Sense when you witness a seizure. Make sure you:

- Clear the area of curious on-lookers. It can be very embarrassing for the person to come out of the seizure to find a crowd gathered around gawking.

- At the end of the seizure, the person may be tired and confused. It is possible the person may also vomit or lose bowel or bladder control so be prepared to deal with this possibility as efficiently and as sensitively as possible.

Arthritis

Arthritis is a disease that can cause swollen joints, pain and loss of movement. People of all ages, even children and young adults, can develop arthritis. There are many types of arthritis that are sometimes known as rheumatic diseases.

Types

1. Osteoarthritis - Appears to be related to overuse and abuse of the joints, often affecting weight-bearing joints such as hips, knees, ankles and hands.
2. Rheumatoid Arthritis - Thought to be hereditary-related and affects the hands, feet and knees.
3. Gout - Affects men more often than women and occurs when the body is unable to properly dispose of uric acid, which form needle-like crystals in the joints and leads to severe inflammation. Gout is thought to be the only form of arthritis that is related to a person’s diet.
4. **Lupus** - Generally affects young women during childbearing years. It inflames and damages many body tissues, joints and internal organs.

5. **Osteoporosis** - Generally affects women over the age of 60 and can cause fractures in the wrists, spine and hips. Can also cause the victim to stoop over.

6. **Juvenile Arthritis** - Affects about 1 out of every 1,000 children and may quiet down as they approach adult years.

The arthritic member may have difficulty walking due to pain or stiffness, be unable to walk or have difficulty with hand functions. Getting up from a lying or sitting position is often slow and painful as well.

**Mobility Impairments**

Mobility impairment refers to any condition that affects a person’s ability to move about, including ambulation. These range from arthritis to disabilities such as MD, CP, paralysis, amputated limbs and, in some instances, stroke victims. A person may also have temporary mobility impairments, such as a cast or recovering from surgery.

**Assisting Techniques**

Passengers who do not use mobility devices may still be mobility-impaired and need help getting on the vehicle and into and out of their seats. Be alert and ready to help members when you ask if they need assistance.

When assisting a person with a cane, let the person take your arm with his/her free hand. You will be able to provide support while reducing the risk of getting in the way of the cane.

When passengers using walkers or canes get on a vehicle, they may want to keep the equipment close to them. For reasons of safety, however, it may be necessary to store and secure such equipment away from the member.

**Spinal Cord Injuries**

A spinal cord injury is a condition (either injury or disease) affecting the spinal cord. The level of damage will determine how much movement or feeling has been affected.

**Types**

1. Paraplegia – paralysis of both legs;
2. Quadriplegia – paralysis of both arms and legs;
3. Hemiplegia – paralysis on one side;
4. Loss of Skin Sensation – may not be able to feel heat/cold or sharp objects. Make sure you check the seats and cushions for sharp objects before your members get in the vehicle. Do not place them in the direct line of the heat or air conditioning.

**Vision Impairment**

People with a vision disability exhibit a wide range of impairments. Some people may have no sight at all while others may have limited vision. The visually impaired may have the following issues:

- A tendency to bump into things or people;
- A tendency to miss a step or stumble over a curb;
- Poor peripheral vision;
- Poor direct vision.

Types
1. **Diabetic Retinopathy** – The most common cause of blindness in the US is diabetic retinopathy, or damage to small blood vessels in the eye because of the body’s failure to produce sufficient insulin. This condition can be treated if diagnosed early.

2. **Cataracts** – A clouding of the lens of the eye; can be corrected by minor surgery.

3. **Night Blindness** – An inability to see in the dark.

4. **Tunnel Vision**: A loss of peripheral vision limiting their sight to only a small area directly in front of him/her.

5. **Glaucoma**: An increase in pressure in the eye due to faulty draining of normal fluids. If caught early, glaucoma can be corrected before any damage occurs. If not, permanent damage to the optic nerve can result. Glaucoma can strike at any age but is more common in the over 40-age group.

Techniques - When transporting a visually impaired person, use the following techniques to assist them:

1. First ask if they need assistance;
2. Let him/her place their hand on your forearm or shoulder;
3. Use a normal tone and speed of voice and speak directly to the person;
4. When giving directions, be as clear and specific as possible;
5. If the member has a service animal, do not pet the animal unless invited to do so;
6. Use common sense and sensitivity;
7. Notify the person if you are leaving their area
Guidelines for assisting those with Hearing Loss:

1. Do not mistake hearing loss in the elderly for mental impairment. In elderly people, hearing impairments and the confusion that often result can be mistaken for Alzheimer’s disease, mental illness or other mental conditions.

2. Experiment with different pitches and levels of loudness. Some people can hear at normal levels but the sound is highly distorted. Speak only slightly louder than normal, find the right volume level and stay at that level. Because some people lose their high frequency hearing, lowering the pitch of your voice can help them hear you more easily.

3. Make sure the passenger can see your face and lips. Do not speak until a hearing impaired person can see you. If necessary, touch the person’s hand to get their attention. Also, never speak directly into a hearing impaired person’s ear. This may make it harder to hear you and prevent the person from watching your expressions.

4. Speak at a normal rate. Speak at your normal rate and avoid chewing gum, eating or covering your mouth with your hands while you are speaking to a hearing impaired individual.

5. Say the same thing in different words. If you suspect you are not being understood, rephrase your statements into shorter, simpler sentences. Then ask the person a related question so you can be sure you are communicating clearly.

6. When speaking through an interpreter, talk to the person with the hearing impairments, not the interpreter.

7. Try sign language or the manual alphabet. Also, commonly understood gestures (pointing, tapping your watch, counting out numbers on your fingers, etc.) can help with communication.

8. Keep a pencil and notepad on the vehicle. It may easiest to communicate with passengers who have hearing impairments by writing notes (although not at the same time you are talking).

9. Remember, passengers with hearing impairments can have balance problems because of problems in the inner ear (which plays an important role in balance). As with other mobility impairments, avoid moving the vehicle until the person is safely seated.
One of the most challenging things a driver will be deal with is communicating with passengers with speech disabilities. It is important that drivers use the following guidelines for dealing with those riders with speech impairments.

1. **Be honest.** Never acknowledge that you have understood what a person has said if, in fact, you have not.

2. **Repeat what you “thought” the person said.** This gives the passenger a chance to confirm or deny what you have said.

3. **Ask the person to repeat** the part you are having trouble understanding. Remember, a person with communication difficulties is quite used to being misunderstood and will appreciate the fact that you are making an effort to understand him/her.

4. **Put the speaker at ease and do not hurry him/her.** If a person becomes tense, almost any type of speech impediment will become worse. Telling the person to “slow down” or “take a deep breath” will not help. If you try to hurry the person, he or she could become stressed which could make the stuttering worse. It is very important to be calm and listen carefully.

5. **Do Not finish the person’s sentence for them;** allow them to finish it.

6. **Do not assume speech impairment is mentally challenged.** Some severely retarded people will also have speech and language impairments. However, many speech-impaired members have normal to very high intelligence. Drivers need to be sensitive to these differences.

7. **Remain calm and patient.** As drivers and their speech-impaired passengers come to know each other better, drivers will become more adept at “hearing” and will learn to understand their riders more easily.
MENTAL IMPAIRMENTS

People who are mentally challenged sometimes have difficulty learning information at the same level as non-challenged people. This means that they may not understand as quickly as other people. How fast they learn and understand depends on the degree of their impairment. A person can be mildly, moderately, severely or profoundly impaired. The more severely mentally challenged a person is, the greater the possibility that he or she will also have other handicaps. It is important for drivers to understand the degree of impairment of your passengers so that you can communicate more effectively with them.

- **Mildly retarded** - They can follow several simple directions.
- **Moderately retarded** - They can follow limited simply directions.
- **Severely retarded** - They will need one-word commands given one at a time. Wait for each direction to be completed before giving the next one.

All of us have experienced the fear that comes with being in an unfamiliar situation. Mentally retarded people are generally more fearful of the unknown or of new things than you are. They may show this fear when they get on your van for the first time. He or she may not understand that you are a nice person who is there to help them. If you are friendly and courteous, all of your riders will feel at ease and come to trust and like you.

*Try to remember that, in general, Mentally Challenged people tend to:*

- Learn more slowly;
- Develop language skills more slowly;
- Need shorter, simpler directions;
- Learn from watching others;
- Like to help.

*Guidelines for dealing with a person with mentally challenged:*

- Keep your concepts clear and concise.
- Give directions one-step at a time.
- Ask first.
- Do not assume that a person with mentally challenged is sick.
- Remember; responses may be slow to come.
- Treat adults as adults.

*Characteristics*

People who are mentally impaired may have the following characteristics:

- Lessened ability to give or understand directions
• A lack of orientation (not aware of where they are or what time it is)
• Agitation, excitability or lack of emotional control
• A hard time learning and remembering rules and regulations

When trying to empathize with the mentally impaired rider, remember:
• Everyone has been confused or disoriented by a new situation
• Everyone has once had a hard time following directions
• Everyone has once had trouble finding his or her way around a new environment
• Everyone has, at times, become agitated, irritated or excited when a familiar routine has suddenly been changed

Assisting Techniques

When assisting mentally impaired passengers, remember to:
• Ask the caretaker how much do they understand
• Ask the caretaker what type of day are they having
• Ask the caretaker is there anything special you need to know
• Repeat yourself; it is often useful
• Be patient and understanding; it is always necessary
• Be firm; passengers may want to do things that are inappropriate or unsafe
• Be alert to potential danger
• Learn from family, counselors and aides
Characteristics

The special assistance needs of the elderly vary greatly from person to person. While each person is unique, some characteristics of elderly people may include:

- **Decreased strength, speed and/or coordination.** Because of these and other physical changes, balance is often impaired and they are more likely to fall. Boarding and disembarking the vehicle can be particularly hazardous. Offer your assistance and stay close.

- **Increase in severity of injuries when they do fall.** Because their bones can be more brittle than those of younger people it is important to help them avoid falls.

- **Impaired vision.** This can make it difficult to judge distances, see steps, etc. To the extent possible, when assisting an elderly person on or off of a vehicle, pull the vehicle close to the curb so the person will not have too far to step.

- **Decreased sense of touch.** This may cause them not to notice touch and they may easily be burned if they sit next to a vehicle heater.

- **Memory loss/confusion.** Age is sometimes accompanied by occasional confusion and loss of memory. Do not lose patience with the elderly; respectfully try to help them get oriented.

- **Sensitivity to heat and cold.** Elderly people are particularly at risk for hypothermia, a condition in which a person suffers permanent damage or even death because of cold. If the vehicle is not well heated or you must turn off the heat for some reason, be sure any elderly passengers on board are well covered. Similarly, elderly passengers can have trouble with excessive heat. In summer, keep the vehicle air-conditioned, park in the shade, seat passengers on the shady side of the vehicle, etc.

- **Isolation.** Sometimes the driver may be the only person who sees the elderly passenger regularly. By being alert to changes in the member’s appearance or condition, the driver may be able to notify dispatchers about possible health problems.
Alzheimer’s disease (AD) can affect memory, speech and other intellectual skills. People with this disease often experience changes in their mood, personality and behavior. They also may get very upset, fearful and/or confused. The following information will help the driver more effectively serve the member with Alzheimer’s disease.

Alzheimer’s is not:

- A natural part of aging
- Curable
- A mental illness
- Contagious

Guidelines

- Because of memory loss, it is often necessary to repeat information to the AD member, even to the extent of telling them their address, where they are going, who they are meeting, etc.

- Sometimes people with AD tend to wander off. Drivers need to be careful of the AD member so they do not get lost or wander into traffic. Drivers need to also make certain these members actually get inside his/her destination.

- Let your dispatcher/Southeastrans know if the person needs to have an escort for safety and health issues.

- Many people with AD wear bracelets identifying their condition and giving their names and addresses. If the person seems lost, drivers can check the bracelet for information that will help you notify a responsible person.

- Dispatchers should be certain that they have a complete and accurate destination and return address for any passengers they know have AD.

- Do not reprimand these passengers for inappropriate behavior because they may not understand what they have done. Instead, talk to the supervisor and staff of the facility where they live or with one of the passengers’ relatives about any problems serving the passenger.
Many disabling conditions are not immediately apparent to drivers. Some of these conditions include:

**Acquired Immune Deficiency Syndrome (AIDS)**

- AIDS is characterized by a defect in the body’s natural immune system. People who have AIDS are vulnerable to serious illnesses that would not be a threat to others whose immune system is functioning normally.

- The virus that causes AIDS, Human Immunodeficiency Virus (HIV), is transmitted through sexual contact, exposure to infected blood or transferred from mother to child in the womb. HIV is not transmitted through casual contact or breathing the same air. Having a person with AIDS on the vehicle does not endanger the driver or the other passengers.

- Some people often reject AIDS members. Usually driver courtesy and concern will be deeply appreciated.

The one way in which you might be at risk of contracting AIDS is if a passenger with AIDS is cut and bleeding. If this happens, get qualified medical help immediately and avoid contact with the passenger’s blood.

**Cardiovascular Disease**

- Even though you may not be able to tell that the passenger has cardiovascular, or heart, disease, he or she may have trouble moving quickly. These passengers may need extra time to get on and off a vehicle.

- People with cardiovascular disease may require extra patience on your part, since they may be fearful of any physical activity.

- Watch for signs of discomfort: sweating, grimaces, fidgeting, etc. Signs of indigestion (taking antacids, for example) may be the first indication of a heart attack or angina (chest pain).

**Respiratory Disorders**

- Emphysema, bronchial asthma and some allergies are examples of respiratory disorders.

- If a passenger has a respiratory attack, he/she probably knows the best way to deal with it. The most helpful thing you can do is to remain calm and to encourage other passengers also to remain calm.

- Keep the air in the vehicle as clean and cool as possible. Closing the windows and using air conditioning helps keep the air clean. Never smoke in the vehicle.
- If you handle a passenger’s breathing equipment, carry the tank carefully, storing or securing it carefully so it won’t fall over and become a safety hazard.

**Kidney Dialysis Treatment**

People who go through kidney dialysis treatment can be extremely weak and feel ill upon completion of treatment. Make absolutely certain that individuals who have undergone this treatment receive assistance (if they need it) and are as comfortable as possible.

**Guidelines**

- Before the person gets into your vehicle ask them how they are feeling. If they are complaining they are light headed, bleeding and/or just not feel right, they need to go back into the dialysis center to be evaluated by the medical staff.
Policies & Procedures

All NEMT providers should have very clear, specific, written procedures for drivers to follow in the event of an accident or other emergency. Dispatchers must also be trained in these policies. The driver is likely to be rattled in a serious accident and the dispatcher can help by reviewing procedures clearly. The more training drivers have in emergencies and first aid, the calmer and more competent they will be in an accident.

Two-Way Communication

All NEMT provider vehicles will be equipped with two-way communication devices so that professional medical assistance can be called immediately in an emergency.

First Aid Kit and Fire Extinguisher

All vehicles must have a first aid kit, spill kit and fire extinguisher. Drivers should regularly check to be certain that the kit is in good order and has everything needed for emergency first aid. They should also be trained in operating the fire extinguisher.

First Aid Procedures

All NEMT drivers must be trained in emergency first aid procedures. The following are some basic first aid procedures for drivers to review.

In an accident:

- Move quickly. The first few minutes are crucial
- Call the nearest law enforcement agency or 911 and follow your company procedures
- If someone is seriously injured, you should only administer basic first aid assistance, i.e., covering the victim to keep him warm, wrapping wounds with clean material, or administering CPR. Place your emergency reflector triangles out (as trained).
- Never move the victim unless it's absolutely necessary for his safety. If you do, make sure you keep him in the same position. In other words, don't drape him over your shoulders; don't bend his neck, waist, or knees; and don't drag him.
- Have other motorists “protect” the scene while you stay with your passengers

Protecting the Scene of an Accident

It is important to “protect” the scene of the accident. Other motorists can assist with this leaving the driver free to take care of passengers. Protecting the accident scene is extremely important in preventing further injuries. Use the following steps to protect the scene of the accident:

- Stop your vehicle at the scene of the accident or, if you need to unblock traffic, as close to the scene as possible.
• Make sure all vehicles involved are turned off.

• Place emergency reflector triangles at each end of the accident area if possible

• Direct traffic around or away from the accident area

• Check for gasoline spills, have a fire extinguisher handy and make sure no one smokes

• Keep people away from the accident

• Try to ensure that only people trained in first aid help the injured

Checking for Injuries

All injuries are serious and need attention. Drivers need to learn to recognize those situations that are life threatening and the techniques to be used. Below are some guidelines for use in evaluating injuries.

• A person ejected from a vehicle is apt to be the most seriously injured

• Extremely critical situations include:
  - Loss of consciousness
  - Head injuries
  - Bleeding
  - Shock
  - Not breathing
  - Loss of consciousness

Do not move the injured unless it is life and death. Moving an accident victim with a head or neck injury can increase the chance for paralysis. Check the injured for shock.

When talking to 911, do not hang up the phone until the 911 dispatcher instruct you to do so. The 911 dispatcher will ask several questions. If possible, notify the 911 dispatcher of the type and extent of injuries to help them be prepared, mile marked are extremely helpful and if you see or smell gas. They will know what kind of help to send and how many ambulances are needed and they will inform you what to do.

Loss of Consciousness

• Be sure the air passage is open. Make sure the tongue is not blocking the air passage. However, do not stick your finger down the throat; this would only push an obstruction farther down

• You can tip the victim’s head back to improve airflow but ONLY IF THERE IS NO POSSIBILITY OF A HEAD OR NECK INJURY

• If there is blood in the mouth or vomiting, turn the head to the side. Again, be alert for possible head and neck injuries

Head Injuries – Head injuries will not always be visible. The following are some guidelines for identifying them:

• Check for bleeding
• Watch for signs of concussion (dilated pupils, nausea, dizziness, loss of consciousness, fluid running from ears, swelling)

• Always suspect a neck injury if there is a head injury

• Leave the injured where they are if at all possible

**Controlling Bleeding**

Bleeding can be controlled in several ways:

• Apply direct pressure over the wound with a clean cloth. If the cloth becomes soaked, do not remove it. Just place a new cloth on top of the other one.

• Direct pressure can also be applied by placing the flat side of your fingers directly over the wound

• Raising the part of the body that is bleeding will slow the bleeding

**Treating Shock**

A person in shock will be cold, clammy and pale and will have a rapid, weak pulse. When you suspect someone is in shock, you should:

• Loosen the victim’s clothing

• Keep the person lying down

• Cover the person to preserve body heat

• Talk to the injured person and provide reassurance that help is coming

**When emergency help arrives, you should:**

• Tell them what types of injuries you suspect

• Tell then what first aid you have given

• Direct them to the most seriously injured person first

• Ask if they need further assistance from you or are you free to leave the scene

Whenever there has been an accident, people tend to panic. This does not help anyone and wastes valuable time. Knowing what to do can help reduce the feeling of panic.

Note: If you member loaded and come upon an accident, activate 911. Inform the 911 dispatcher that you are patient loaded and are unable to leave the patients alone.
Social and emotional disabilities refer to behavior, something that can be observed. Behavior can be inwardly or outwardly directed.

**Outwardly Directed** – Behavior that is outwardly directed is disturbing to others and to the environment around the person. When inappropriate behavior occurs on your vehicle you must do something to stop or change the behavior. You can gain control of the situation by directing a rider’s undesirable behavior away from riders towards you as the receiver of that behavior. It is usually helpful to attempt to determine the cause of the behavior and whom the behavior is being directed toward.

One way to discourage undesirable behavior is to ignore it. If you choose this method, you should be aware of the following:

- The behavior will probably get worse before it gets better; be sure you can wait it out
- It is important that everyone ignore the behavior before it will go away. If you ignore a member’s behavior and the rest of your passengers laugh, this method will not work

**Inwardly Directed**

- Such behavior does not involve other people but can also be inappropriate or disruptive. It may appear that the member is unaware of his/her surroundings.
- They may talk to themselves or repeat certain phrases over and over. Do not become alarmed; this person is not psychotic. The rider may be repeating phrases from conversations that were overheard or a catchy phrase picked up from his/her environment.
- It is possible that the member’s strange talk is self-motivated, or created in his/her own mind for his/her own amusement.

Inwardly directed behavior can be more difficult to manage since the driver is not able to redirect the behavior toward him/her. Do not worry too much about a member’s inwardly directed behavior unless the member becomes significantly agitated and/or begins to produce self-destructive behavior. In this instance, it is important to notify your dispatcher/Southeastrans so the serving agency and/or the family can be informed as soon as possible and let them know what behavior you are seeing. An incident report will need to be completed.

The environment can also have a profound effect on one’s behavior. Prior to a member gets on the van, he may have come from an environment that was very disturbing and could bring that problem onto the van. By being alert and paying attention to a member’s mood, a driver will be able to alert caretakers to potential problems, both at home and away from home.
The atmosphere on a vehicle can also affect the behavior of passengers and should be kept neat, clean and in good shape. This sends a message to riders about the driver’s attitude and they will respond. They will come to appreciate its cleanliness and comfort.

It is important to remember that you are a part of the environment of your vehicle. If you are cheerful, chances are that your passengers will be cheerful too. How you talk with them and respond to their needs tells them whether or not your vehicle is a safe, comfortable place to travel in.
APPENDIX F
(CRA ATTACHMENT XI)
NEMT REQUIREMENTS

A.1 GENERAL

A.1.1 The CONTRACTOR, in its delivery of NEMT services, shall comply with all of the requirements in this Attachment XI. The requirements in this Attachment are in addition to, not instead of, requirements found elsewhere in the Agreement.

A.1.2 The CONTRACTOR shall develop written policies and procedures that describe how the CONTRACTOR, in the delivery of NEMT services, shall comply with the requirements of the Agreement, including this Attachment. Pursuant to Section 2.25.4 of the Agreement, TENNCARE will specify the policies and procedures that must be prior approved in writing by TENNCARE. As part of its policies and procedures the CONTRACTOR shall develop an operating procedures manual detailing procedures for meeting, at a minimum, requirements regarding the following:

A.1.2.1 Requesting NEMT services (see Section A.3 of this Attachment);

A.1.2.2 Approving NEMT services (see Section A.4 of this Attachment);

A.1.2.3 Scheduling, assigning and dispatching trips (see Section A.5 of this Attachment).

A.1.3 The CONTRACTOR shall develop and submit to the Division of TennCare for approval, a policy addressing No-Shows which limits the amount of trips a member can take when the CONTRACTOR has determined that the member has missed scheduled trips for NEMT services for a designated number of trips. Upon the approval of these policies by the Office of Contract Compliance, the CONTRACTOR shall assure all policies are implemented and followed by their NEMT brokers and their providers.

A.2 NEMT READINESS REVIEW

The readiness review referenced in Section 2.1.2 of the Agreement shall include NEMT. As part of the readiness review the CONTRACTOR shall demonstrate its ability to meet the NEMT requirements of the Agreement, including this Attachment.

A.3 REQUESTING NEMT SERVICES

A.3.1 Members or their representatives shall be allowed to make requests for NEMT services on behalf of members. For DCS enrollees (as defined in Exhibit A of this Attachment), representatives include the member’s DCS liaison, foster parent,
adoptive parent, or provider. For members enrolled in an HCBS waiver for persons with Intellectual Disabilities, the member’s Independent Support Coordinator/Case Manager or the member’s residential or day services provider may make requests for NEMT services, even when the member’s residential or day services provider is also the contract provider that will deliver the NEMT services to the member.

A.3.2 Requests for NEMT services should be made at least seventy-two (72) hours before the NEMT service is needed. However, this timeframe does not apply to urgent trips (see Section A.5.7 of this Attachment), scheduling changes initiated by the provider, and follow-up appointments when the timeframe does not allow advance scheduling. In addition, the CONTRACTOR shall accommodate requests for NEMT services that are made within the following timeframes: three (3) hours before the NEMT service is needed when the pick-up address is in an urban area and four (4) hours before the NEMT service is needed when the pick-up address is in a non-urban area. The CONTRACTOR shall provide additional education to members who fail to request transportation seventy-two (72) hours before the NEMT service is needed (see Section A.10 of this Attachment).

A.3.3 The CONTRACTOR shall not have a time limit for scheduling transportation for future appointments. For example, if a member calls to schedule transportation to an appointment that is scheduled in two (2) months, the CONTRACTOR shall arrange for that transportation and shall not require the member to call back at a later time. Members identified as a No Show and have been placed on probation may be required to call back at a later time.

A.4 APPROVING NEMT SERVICES

A.4.1 General

A.4.1.1 Transportation for a minor child shall not be denied pursuant to any policy that poses a blanket restriction due to member’s age or lack of accompanying adult. Any decision to deny transportation of a minor child due to a member’s age or lack of an accompanying adult shall be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the “mature minor exception” to permission for medical treatment. The age of consent for children with mental illness is sixteen (16) (see TCA 33-8-202).

A.4.1.2 As part of the approval process, the CONTRACTOR shall:

A.4.1.2.1 Collect relevant information from the caller and enter it into the CONTRACTOR’s system (see Section A.5.10 of this Attachment);

A.4.1.2.2 Verify the member’s eligibility for NEMT services;

A.4.1.2.3 Determine the appropriate mode of transportation for the member;
A.4.1.2.4 Determine the appropriate level of service for the member;
A.4.1.2.5 Approve or deny the request; and
A.4.1.2.6 Enter the appropriate information into the CONTRACTOR’s system (see Section A.5.10 of this Attachment).

A.4.2 Verifying Eligibility for NEMT Services

A.4.2.1 The CONTRACTOR shall screen all requests for NEMT services to confirm each of the following items:
A.4.2.2 That the person for whom the transportation is being requested is a TennCare enrollee and enrolled in the CONTRACTOR’s MCO;
A.4.2.3 That the service for which NEMT service is requested is a TennCare covered service (as defined in Exhibit A of this Attachment);
A.4.2.4 That the enrollee is eligible in accordance with policies and procedures approved by the Office of Contract Compliance regarding No-Show; and
A.4.2.5 That the transportation is a covered NEMT service (see Section 2.6.1.3 of the Agreement).

A.4.3 Determining the Appropriate Mode of Transportation

A.4.3.1 General
A.4.3.1.1 If the criteria in Section A.4.2 of this Attachment are met, the CONTRACTOR shall determine what mode of transportation is appropriate to meet the needs of the member. The modes of transportation that shall be covered by the CONTRACTOR include, but are not limited to: fixed route, multi-passenger van, wheelchair van, invalid vehicle, and ambulance.

A.4.3.1.2 In order to determine the appropriate mode of transportation, the CONTRACTOR shall:
A.4.3.1.2.1 Determine whether the member is ambulatory and the member’s current level of mobility and functional independence;
A.4.3.1.2.2 Determine whether the member will be accompanied by an escort, and, if so, whether the member requires assistance and whether the escort meets the requirements for an escort (see TennCare rules and regulations);
A.4.3.1.2.3 Determine whether a member is under the age of eighteen (18) and will be accompanied by an adult; and

A.4.3.1.2.4 Assess any special conditions or needs of the member, including physical or mental disabilities.

A.4.3.2 Fixed Route

A.4.3.2.1 The CONTRACTOR shall utilize fixed route transportation whenever available and appropriate to meet the needs of the member.

A.4.3.2.2 The CONTRACTOR shall be familiar with schedules of fixed route transportation in communities where it is available and where it becomes available during the term of the Agreement.

A.4.3.2.3 The CONTRACTOR shall distribute and/or arrange for the distribution of fixed route tickets, tokens or passes to members for whom fixed route transportation is available and appropriate. The CONTRACTOR shall have controls in place to track the distribution of tickets/tokens/passes. The CONTRACTOR shall use best efforts that tickets/tokens/passes are used appropriately.

A.4.3.2.4 The CONTRACTOR shall consider the following when determining whether fixed route transportation is available and appropriate for a member:

A.4.3.2.4.1 The furthest distance a member shall be required to travel to or from a fixed route transportation stop is one-third (1/3) of a mile;

A.4.3.2.4.2 The member shall not be required to change buses/trolleys more than once each leg of the trip;

A.4.3.2.4.3 Using fixed route transportation shall not increase travel time more than sixty (60) minutes as compared to transportation directly from the pick-up location to the drop-off destination;

A.4.3.2.4.4 The fixed route transportation schedule shall allow the member to arrive at the destination no more than sixty (60) minutes prior to the scheduled appointment time and shall be flexible on the return so that the member does not have to wait at the pick-up location more than sixty (60) minutes after the estimated time the appointment will end;

A.4.3.2.4.5 Whether fixed route transportation is appropriate based on the member’s physical or mental disabilities; and
A.4.3.2.4 Whether using fixed route for the requested trip is appropriate considering the accessibility of the stops and the safety in accessing the stops.

A.4.3.2.5 Fixed route shall not be appropriate for a member whose physician states in writing that the member cannot use fixed route transportation.

A.4.3.3 Ambulance

The CONTRACTOR’s policies and procedures regarding the appropriateness of using an ambulance to provide covered NEMT services shall be based on Medicare’s medical necessity requirements (see, e.g., 42 CFR 410.40 and Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services).

A.4.4 Determining Level of Service

A.4.4.1 The CONTRACTOR shall assess the member’s needs to determine whether the member requires curb-to-curb, door-to-door, or hand-to-hand service (as these terms are defined in Exhibit A of this Attachment).

A.4.4.2 The CONTRACTOR may require a medical certification statement from the member’s provider in order to approve door-to-door or hand-to-hand service. Medical certification shall be completed within the timeframes specified in Section A.5.1.4 of this Attachment.

A.4.4.3 The CONTRACTOR shall ensure that members receive the appropriate level of service.

A.4.4.4 Failure to comply with requirements regarding level of service may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.4.5 Standing Orders

A.4.5.1 Except as provided in this Section A.4.5, the approval of Standing Orders by the CONTRACTOR shall be consistent with the requirements in Sections A.4.1 through A.4.4.

A.4.5.2 In order to approve a Standing Order (as defined in Exhibit A of this Attachment), the CONTRACTOR shall, at a minimum, call the provider to verify the series of appointments. The CONTRACTOR may, at its discretion, require that the member’s provider certify the series of appointments in writing.
A.4.5.3 The CONTRACTOR shall approve Standing Orders consistent with the series of appointments. For example, if the member has a series of appointments over six (6) months, the CONTRACTOR shall approve transportation for each trip, including all legs of the trip, for the six (6) months. However, the CONTRACTOR shall verify the member’s eligibility prior to each pick-up. The CONTRACTOR may verify additional information before each pick-up as necessary.

A.4.6 Validating Requests

A.4.6.1 The CONTRACTOR shall conduct random pre-transportation validation checks prior to the Member receiving the service in order to prevent fraud and abuse. The amount validated shall be two percent (2%) of NEMT scheduled trips per month.

A.4.6.2 The CONTRACTOR may verify the need for an urgent trip with the provider prior to approving the trip.

A.4.6.3 If requested by TENNCARE, the CONTRACTOR shall conduct pre-transportation validation checks of trips requested by specified members and/or to specific services or providers.

A.4.6.4 Focus of the Pre-Validations shall be, but may not be limited to, members who utilize NEMT services frequently but do not have standing orders as well as members who routinely do not adhere to the seventy-two (72) hour notice requirement.

A.4.6.5 All pre-transportation validation checks shall be conducted within the timeframes specified in Section A.5.1.4 of this Attachment.

A.5 SCHEDULING, ASSIGNING, AND DISPATCHING TRIPS

A.5.1 General

A.5.1.1 The CONTRACTOR shall ensure that covered NEMT services are available twenty-four (24) hours a day, three hundred and sixty-five (365) days a year.

A.5.1.2 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider (see A.5.3 for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities).

A.5.1.3 After approving a NEMT service to be provided by a NEMT provider (i.e., not fixed route), the CONTRACTOR shall schedule and assign the trip to an appropriate NEMT provider.

A.5.1.4 The CONTRACTOR shall approve and schedule or deny a request for transportation (including all legs of the trip) within twenty-four (24)
hours of receiving the request. This timeframe shall be reduced as necessary to ensure the member arrives in time for his/her appointment. Failure to comply with this requirement may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.1.5 The CONTRACTOR shall ensure that trips are dispatched appropriately and meet the requirements of this Attachment. The dispatcher shall, at minimum, provide updated information to drivers, monitor drivers’ locations, and resolve pick-up and delivery issues.

A.5.1.6 Failure to comply with requirements regarding scheduling, assigning and dispatching trips may result in liquidated damages as provided in Section E.29.2 of the CRA (as defined in Exhibit E of the Agreement), Section A.20 of this Exhibit G, and/or Exhibit F of this Exhibit G.

A.5.2 Multi-Passenger Transportation

A.5.2.1 The CONTRACTOR may group enrollees and trips (or legs of trips) to promote efficiency and cost effectiveness. The CONTRACTOR may contact providers if necessary to coordinate multi-passenger transportation.

A.5.2.2 For multi-passenger trips, the CONTRACTOR shall schedule each trip leg so that a member does not remain in the vehicle for more than one (1) hour longer than the average travel time for direct transportation of that member.

A.5.2.3 Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider’s office or facility has opened their doors.

A.5.3 Choice of NEMT Provider

Except for persons enrolled in an HCBS waiver for persons with Intellectual Disabilities, the CONTRACTOR is not required to use a particular NEMT provider or driver requested by the member. However, the CONTRACTOR may accommodate a member’s request to have or not have a specific NEMT provider or driver. If an HCBS waiver participant’s residential or day services waiver provider is enrolled with the CONTRACTOR as an NEMT provider (pursuant to A.12.5), the CONTRACTOR shall permit the residential or day services waiver provider to provide medically necessary, covered NEMT services for waiver participants receiving HCBD ID waiver services from the provider, so long as the provider is able to provide the appropriate mode and level of service in a timely manner.
A.5.4 Notifying Members of Arrangements

If possible, the CONTRACTOR shall inform the member of the transportation arrangements (see below) during the phone call requesting the NEMT service. Otherwise, the CONTRACTOR shall obtain the member’s preferred method (e.g., phone call, email, fax) and time of contact, and the CONTRACTOR shall notify the member of the transportation arrangements (see below) as soon as the arrangements are in place (within the timeframe specified in Section A.5.1.4 of this Attachment) and prior to the date of the NEMT service. Responsibility of determining whether transportation arrangements have been made shall not be delegated to the member. Information about transportation arrangements shall include but not be limited to the name and telephone number of the NEMT provider, the scheduled time and address of pick-up, and the name and address of the provider to whom the member seeks transport.

A.5.5 Notifying NEMT Providers

A.5.5.1 The CONTRACTOR shall provide a trip manifest to the NEMT provider of all new trips requested prior to 5 p.m. on the same business day.

A.5.5.2 The CONTRACTOR shall have the ability to send trip manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. The CONTRACTOR shall ensure that provision of the trip manifest is in compliance with HIPAA requirements (see Section 2.27 of the Agreement). The CONTRACTOR shall have dedicated telephone lines available at all times for faxing purposes.

A.5.5.3 The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip, including but not limited to the information listed in Exhibit B of this Attachment.

A.5.5.4 If the CONTRACTOR notifies a NEMT provider of a trip assignment after the timeframe specified in Section A.5.5.1, the CONTRACTOR shall also contact the NEMT provider by telephone and electronically to confirm that the trip will be accepted.

A.5.5.5 The CONTRACTOR shall communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary trips.

A.5.6 Accommodating Scheduling Changes

A.5.6.1 The CONTRACTOR shall accommodate unforeseen schedule changes and shall timely assign the trip to another NEMT provider if necessary.

A.5.6.2 The CONTRACTOR shall ensure that neither NEMT providers nor drivers change the assigned pick-up time without permission from the
A.5.7 **Urgent Trips**

For urgent trips (as defined in Exhibit A of this Attachment), the CONTRACTOR shall contact an appropriate NEMT provider so that pick-up occurs within three (3) hours after the CONTRACTOR was notified when the pick-up address is in an urban area and four (4) hours after the CONTRACTOR was notified when the pick-up address is in a non-urban area. Trip mileage does not determine if a trip is urban or non-urban. As provided in Section A.4.6.2 of this Agreement, the CONTRACTOR may verify the need for an urgent trip. Failure to comply with requirements regarding urgent trips may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.5.8 **Adverse Weather Plan**

The CONTRACTOR shall have policies and procedures for transporting members who need critical medical care, including but not limited to renal dialysis and chemotherapy, during adverse weather conditions. “Adverse weather conditions” includes, but is not limited to, extreme heat, extreme cold, flooding, tornado warnings and heavy snowfall. The policies and procedures shall include, at a minimum, staff training, methods of notification, and member education.

A.5.9 **Contingency and Back-Up Plans**

The CONTRACTOR shall have policies and procedures that describe contingency plans for unexpected peak transportation demands and back-up plans for instances when a vehicle is excessively late (more than twenty (20) minutes late) or is otherwise unavailable for service.

A.5.10 **Approval and Scheduling System Features**

A.5.10.1 Each transportation request processed by the CONTRACTOR shall be assigned a unique number, shall contain all pertinent information about the request, and shall be available to NEMT Call Center staff. This information shall include, but not be limited to the following:

A.5.10.1.1 Verification of member’s TennCare eligibility (e.g., member name, address, Medicaid ID number, and telephone number if available; eligibility start and end dates);

A.5.10.1.2 Determination that service is a TennCare covered service (e.g., level of service) (see Section A.4.2 of this Attachment);

A.5.10.1.3 Determination that the transportation is a covered NEMT service (see Section A.4.2 of this...
A.5.10.1.4 Determination of the appropriate mode of transportation (e.g., member’s requested mode of transportation, member’s special needs, availability and appropriateness of fixed route, the approved mode of transportation, justification for the approved mode of transportation);

A.5.10.1.5 Determination of the appropriate level of service (see Section A.4.4 of this Attachment);

A.5.10.1.6 Information regarding Standing Orders (if applicable) (see Section A.4.5 of this Attachment);

A.5.10.1.7 Information about whether the request was modified, approved or denied and how the member was notified;

A.5.10.1.8 Information about approved and scheduled transportation (e.g., elements required for the trip manifest; see Section A.5.5 of this Attachment);

A.5.10.1.9 Whether the request was validated;

A.5.10.1.10 Timeframes for the approval process (e.g., date and time of request, determination, scheduling, and notification of member); and

A.5.10.1.11 If applicable, reason for trip cancellation.

A.5.10.2 The CONTRACTOR’s approval and scheduling systems shall be coded such that policies and procedures are applied consistently.

A.5.10.3 Based on approval of previous NEMT services, the CONTRACTOR shall display members’ permanent and temporary special needs, appropriate mode of transportation, and any other information necessary to ensure that appropriate transportation is approved and provided. All of this information shall be easily accessible by all NEMT Call Center staff.

A.5.10.4 The CONTRACTOR’s approval and scheduling systems shall also support the following:

A.5.10.4.1 A database of NEMT providers that includes information needed to determine trip assignments such as but not limited to: types of vehicles, number of vehicles by type, lift capacity of vehicles, and geographic coverage.
A.5.10.4.2 Automatic address validations, distance calculations and trip pricing, if applicable;

A.5.10.4.3 Ability to generate a trip manifest (see Section A.5.5 of this Attachment);

A.5.10.4.4 Standing Order and Single Trip (as defined in Exhibit A of this Attachment) reservation capability; and

A.5.10.4.5 Ability to determine if fixed route transportation is available and appropriate for the member.

A.5.10.5 The CONTRACTOR’s approval and scheduling system shall enable report and data submission as specified in the Agreement.

A.6 PICK-UP AND DELIVERY STANDARDS

A.6.1 The CONTRACTOR shall ensure that NEMT providers arrive on time for scheduled pick-ups. The NEMT provider may arrive before the scheduled pick-up time, but the member shall not be required to board the vehicle prior to the scheduled pick-up time.

A.6.2 The CONTRACTOR shall ensure that drivers make their presence known to the member and wait until at least five (5) minutes after the scheduled pick-up time. If the member is not present five (5) minutes after the scheduled pick-up time, the driver shall notify the dispatcher before departing from the pick-up location.

A.6.3 The CONTRACTOR shall ensure that drivers provide, at a minimum, the approved level of service (curb-to-curb, door-to-door, or hand-to-hand).

A.6.4 The CONTRACTOR shall ensure that members arrive at pre-arranged times for appointments and are picked up at pre-arranged times for the return leg of the trip. If there is no pre-arranged time for the return leg of the trip, the CONTRACTOR shall ensure that members are picked up within one (1) hour after notification. Pick-up and drop-off times should be captured in such a way to allow reporting as requested by TENNCARE. Members shall not be required to arrive at their scheduled appointment more than one (1) hour before their appointment time. Members shall not be dropped off for their appointment before the provider’s office or facility has opened their doors.

A.6.5 The CONTRACTOR shall ensure that the waiting time for members for pick-up does not exceed ten (10) minutes past the scheduled pick-up time. Scheduled pick-up times shall allow the appropriate amount of travel time to assure the members arrive giving them sufficient time to check-in for their appointment. Members shall be dropped off for their appointment no less than fifteen (15) minutes prior to their appointment time to prevent the drop off time from being considered a late drop off.
A.6.6 The CONTRACTOR shall ensure that if the driver will not arrive on time to the pick-up location, the driver shall notify the dispatcher, and the member is contacted.

A.6.7 The CONTRACTOR shall ensure that if the driver will not arrive on time to an appointment, the driver shall notify the dispatcher, and the provider is contacted.

A.6.8 The driver may refuse transportation when the member, his/her escort, or an accompanying adult (for a member under age eighteen (18)), according to a reasonable person’s standards, is noticeably indisposed (disorderly conduct, indecent exposure, intoxicated), is armed (firearms), is in possession of illegal drugs, knives and/or other weapons, commits a criminal offense, or is in any other condition that may affect the safety of the driver or persons being transported. The CONTRACTOR shall ensure that if a driver refuses to transport a member the driver immediately notifies the dispatcher, and the dispatcher notifies the CONTRACTOR.

A.6.9 The CONTRACTOR shall ensure that in the event of an incident or accident (see Section A.17.2 of this Attachment), the driver notifies the dispatcher immediately to report the incident or accident and that, if necessary, alternative transportation is arranged. The CONTRACTOR shall ensure that it is promptly notified of any incident or accident.

A.6.10 Failure to comply with requirements regarding pick-up and delivery standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.7 VEHICLE STANDARDS

A.7.1 The CONTRACTOR shall ensure that all vehicles meet or exceed applicable federal, state, and local requirements and manufacturer’s safety, mechanical, operating, and maintenance standards while maintaining proof of compliance as to allow for unscheduled file audits.

A.7.2 The CONTRACTOR shall ensure that all vehicles comply with the vehicle requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements in this Section, and the requirements in Exhibit C of this Attachment.

A.7.3 The CONTRACTOR shall ensure that any vehicle used to cross a state’s border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.7.4 The CONTRACTOR shall ensure that each vehicle has a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute for this requirement.

A.7.5 The CONTRACTOR shall ensure that all vehicles transporting members with disabilities comply with applicable requirements of the Americans with
Disabilities Act (ADA), including the accessibility specifications for transportation vehicles.

A.7.6 The CONTRACTOR shall ensure that, at minimum, all vehicles providing stretcher transport are owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH’s requirements for ground invalid vehicles.

A.7.7 The CONTRACTOR shall ensure that, except as otherwise permitted by State of Tennessee law, all ambulances are owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with DOH’s requirements for ambulances. The CONTRACTOR shall also ensure that vehicles comply with any applicable local requirements.

A.7.8 As required in Section A.17 of this Attachment, the CONTRACTOR shall inspect all vehicles (except fixed route, invalid vehicles, and ambulances) for compliance with applicable requirements and shall immediately remove any vehicle that is out of compliance.

A.7.9 Failure to comply with requirements regarding vehicle standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.8 TRAINING AND STANDARDS FOR DRIVERS

A.8.1 The CONTRACTOR shall ensure that all drivers receive appropriate training and meet applicable standards, as specified in this Section A.8. These requirements do not apply to drivers of fixed route transportation. Drivers of fixed route transportation shall comply with all rules, regulations, policies and procedures promulgated by the fixed route carrier, federal, state or local law.

A.8.2 Driver Training

A.8.2.1 The CONTRACTOR shall ensure that all drivers receive appropriate training prior to providing services under the Agreement and annually thereafter. This shall include a minimum of thirty-two (32) hours of training prior to providing services under the Agreement and a minimum of fifteen (15) hours of annual training. Proof of all required training shall be maintained as to allow for unscheduled file audits.

A.8.2.2 Driver training shall include, at a minimum the following:

A.8.2.2.1 Customer service;

A.8.2.2.2 Passenger assistance;

A.8.2.2.3 Sensitivity training;
A.8.2.2.4 Behavioral health and substance abuse issues;

A.8.2.2.5 Title VI requirements (Civil Rights Act of 1964);

A.8.2.2.6 HIPAA privacy requirements;

A.8.2.2.7 ADA requirements;

A.8.2.2.8 Wheelchair securement/safety;

A.8.2.2.9 Seat belt usage and child restraints;

A.8.2.2.10 Handling and reporting accidents and incidents;

A.8.2.2.11 Emergency evacuation;

A.8.2.2.12 Daily vehicle inspection;

A.8.2.2.13 Defensive driving;

A.8.2.2.14 Risk management;

A.8.2.2.15 Communications;

A.8.2.2.16 Infection control;

A.8.2.2.17 Annual road tests; and

A.8.2.2.18 Reporting enrollee and provider fraud and abuse.

A.8.3 Standards for Drivers

A.8.3.1 The CONTRACTOR shall ensure that all drivers comply with driver requirements developed by the CONTRACTOR and prior approved in writing by TENNCARE, which at a minimum shall include compliance with applicable federal, state, and local requirements, the requirements of this Section, and the requirements in Exhibit D of this Attachment.

A.8.3.2 The CONTRACTOR shall ensure that all drivers are at least eighteen (18) years of age and have a Class D driver license with F (for hire endorsement) or commercial driver license (Class A, B, or C) issued by the State of Tennessee or the equivalent licensure issued by the driver’s state of residence.

A.8.3.3 The CONTRACTOR shall ensure that all drivers meet the State of Tennessee requirements regarding proof of financial responsibility and/or insurance.
A.8.3.4 The CONTRACTOR shall ensure that any driver that crosses a state’s border complies with any and all applicable federal, state (State of Tennessee and/or other state), and local requirements.

A.8.3.5 The CONTRACTOR shall ensure that any personnel contracted by or employed by a NEMT provider to provide medical assistance to a member during a non-emergency ambulance trip is licensed by the State of Tennessee as an emergency medical technician (EMT) and complies with DOH requirements for EMTs.

A.8.3.6 The CONTRACTOR shall ensure that all drivers pass a physical examination prior to providing services under the Agreement and have additional physical examinations as necessary to ensure that a driver is qualified to drive a passenger vehicle (e.g., if the driver has a heart attack or stroke). The physical examination shall be at least as extensive as the medical examination required by the United States Department of Transportation’s Federal Motor Carrier Safety Administration (FMCSA) for commercial drivers. Proof of exams shall be maintained in the driver file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor’s, etc.) must contain an attestation signed by the driver including the effective dates of the physical examination.

A.8.3.7 The CONTRACTOR shall ensure that all drivers pass a drug test prior to providing services under the Agreement. In addition, the CONTRACTOR shall ensure that an alcohol and drug test is conducted when a trained supervisor/employer of a driver has reasonable suspicion to believe that the driver has violated the CONTRACTOR’s policies and procedures regarding use of alcohol and/or controlled substances, that random drug and alcohol tests are conducted, and that post accident drug and alcohol testing is conducted. The Contractor shall ensure that all drivers have been tested within the last five (5) years in the event they have not been randomly selected for testing. The CONTRACTOR’s policies and procedures for drug and alcohol testing shall, at a minimum, meet the FMCSA’s alcohol and drug testing requirements for motor carriers. Drivers should be randomly selected from the current utilized drivers for drug and alcohol testing with no less than twenty percent (20%) of drivers tested per calendar year. The drivers tested shall be reported to TENNCARE quarterly as described in the reporting section of this Attachment XI. Results of drug and alcohol testing shall be maintained in the driver’s file as to allow for unscheduled file audits. All driver files (including but not limited to, HRAs, private vendor’s, etc.) must contain an attestation signed by the driver containing the date of the drug and alcohol test if the actual test results cannot be provided.

A.8.3.8 The CONTRACTOR shall ensure that criminal background checks pursuant to TCA 38-6-109 as well as national criminal background
checks are conducted for all drivers prior to providing services under the Agreement and every five years thereafter. The CONTRACTOR shall develop a list of disqualifying criminal offenses, which at a minimum shall include the permanent and interim disqualifying criminal offenses that apply to applicants for a hazardous materials endorsement in Tennessee. Drivers that have been convicted, pled guilty or found not guilty by reason of insanity of any of the disqualifying criminal offenses shall not provide services under the Agreement. Results of background checks shall be maintained in the drivers file as to allow for unscheduled file audits.

A.8.3.9 The CONTRACTOR shall ensure that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the Agreement.

A.8.3.10 The CONTRACTOR shall ensure that no driver has been convicted of a criminal offense related to the driver’s involvement with Medicare, Medicaid, or the federal Title XX services program (see Section 1128 of the Social Security Act and 42 CFR 455.106).

A.8.3.11 The CONTRACTOR shall verify that drivers are not listed on the Tennessee Sexual Offender Registry and the equivalent registry showing data from all 50 states. This is in addition to the criminal background check and results shall be maintained in the driver’s file as to allow for unscheduled file audits.

A.8.3.12 The CONTRACTOR shall ensure that drivers maintain an acceptable Motor Vehicle Report containing data for any state the driver has previously lived prior to providing services under the Agreement and annually thereafter. Annual updates shall only contain information for the states the driver has resided in since the last update. The Motor Vehicle Report shall, at a minimum, show the following:

A.8.3.12.1 No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;

A.8.3.12.2 No conviction for reckless driving within the previous thirty-six (36) month period;

A.8.3.12.3 No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;

A.8.3.12.4 No conviction for a felony involving the use of an automobile within the previous thirty-six (36) months;

A.8.3.12.5 Conviction for no more than two (2) minor moving traffic violations
such as speeding, failure to stop, or improper operation of a motor vehicle within the previous twelve (12) months;

A.8.3.12.6 Conviction for no more than one (1) at-fault accident resulting in personal injury or property damage within the previous thirty-six (36) months; and

A.8.3.12.7 Not have a combination of conviction for one (1) at-fault accident resulting in personal injury or property damage and conviction for one (1) unrelated minor moving traffic violation within the previous thirty-six (36) months.

A.8.3.13 The CONTRACTOR shall require that drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies the CONTRACTOR of any moving traffic violation or if a driver’s license is suspended or revoked.

A.8.3.14 The CONTRACTOR shall ensure that all ambulance drivers and invalid vehicle drivers comply with applicable DOH and local requirements.

A.8.3.15 The CONTRACTOR shall require that drivers maintain daily transportation logs containing, at a minimum, the information listed in Exhibit E of this Attachment.

A.8.3.16 As required in Section A.17 of this Attachment, the CONTRACTOR shall monitor drivers and immediately remove any driver that is out of compliance with applicable requirements.

A.8.3.17 Proof of compliance of each driver requirement shall be maintained in the driver file as to allow for unscheduled file audits.

A.8.4 Failure to comply with requirements regarding driver training and driver standards may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.9 NEMT CALL CENTER

A.9.1 The CONTRACTOR shall maintain a NEMT Call Center to handle requests for NEMT services as well as questions, comments, and inquiries from members and their representatives, NEMT providers, and providers regarding NEMT services. The NEMT Call Center may use the same infrastructure as the CONTRACTOR’s member services line, but the CONTRACTOR shall have a separate line or queue for NEMT calls, and NEMT Call Center staff shall be dedicated to NEMT calls.

A.9.2 The NEMT Call Center shall be appropriately staffed twenty-four (24) hours a day, seven (7) days a week, three hundred and sixty-five (365) days a year to handle the call volume in compliance with the performance standards in Section A.9.6 of this Attachment. The CONTRACTOR shall ensure continuous
availability of NEMT Call Center services.

A.9.3 Between the hours of 7:00 PM and 5:00 AM in the time zone applicable to the Grand Region served by the CONTRACTOR (for example, in Middle, the applicable time zone shall be Central Time), the CONTRACTOR may use alternative arrangements to handle NEMT calls so long as there is no additional burden on the caller (e.g., the caller is not required to call a different number or to make a second call), and the call is promptly returned by the CONTRACTOR.

A.9.4 For hours that the CONTRACTOR is using alternative arrangements to handle NEMT calls (see Section A.9.3 of this Attachment), the CONTRACTOR shall provide an afterhours message in, at a minimum, English and Spanish instructing the caller how to access the alternative arrangement (not requiring a second call) and also offering the caller the opportunity to leave a message utilizing a process in which all messages are returned within (3) three hours and efforts continue until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate compliance with this requirement.

A.9.5 The CONTRACTOR’s NEMT Call Center system shall have the capability to identify and record the phone number of the caller if the caller’s phone number is not blocked.

A.9.6 The CONTRACTOR shall have the capability of making outbound calls.

A.9.7 The CONTRACTOR shall maintain sufficient equipment and NEMT Call Center staff to handle anticipated call volume and ensure that calls are received and processed in accordance with the requirements of this Section A.9 and the following performance standards for each line or queue:

A.9.7.1 Answer rate – At least eighty-five percent (85%) of all calls are answered by a live voice within thirty (30) seconds;

A.9.7.2 Abandoned calls – No more than five percent (5%) of calls are abandoned; and

A.9.7.3 Hold time – Average hold time, including transfers to other CONTRACTOR staff, is no more than three (3) minutes.

A.9.8 If a NEMT call cannot be answered by a live voice within thirty (30) seconds, the CONTRACTOR shall provide a message in, at a minimum, English and Spanish advising the caller that the call will not be answered promptly and offering the caller the opportunity to leave a message. If the message requests the CONTRACTOR to return the call, the CONTRACTOR shall promptly return the call within three (3) hours and continue the effort until the member is reached provided that the message left by the enrollee is discernible and includes a valid phone number in which the enrollee can be contacted. All efforts made to reach a member who has left a message shall be documented in order to demonstrate
compliance with this requirement.

A.9.9 The CONTRACTOR shall have qualified bi-lingual (English and, at minimum, Spanish) NEMT Call Center staff to communicate with callers who, at a minimum, speak Spanish. The CONTRACTOR shall provide oral interpretation services via a telephone interpretation service free of charge to callers with Limited English Proficiency.

A.9.10 The CONTRACTOR’s NEMT Call Center shall accommodate callers who are hearing and/or speech impaired.

A.9.11 The CONTRACTOR shall operate an automatic call distribution system for its NEMT Call Center.

A.9.12 The CONTRACTOR shall route incoming calls to the NEMT Call Center to, at minimum, an English-speaking member queue, a Spanish-speaking member queue, a NEMT provider queue, and a provider healthcare queue.

A.9.13 The welcome message for the NEMT Call Center shall be in English and shall include, at minimum, a Spanish language prompt.

A.9.14 The CONTRACTOR shall develop NEMT Call Center scripts for calls requesting NEMT services that include a sequence of questions and criteria that the NEMT Call Center representatives shall use to determine the member’s eligibility for NEMT services, the appropriate mode of transportation, the purpose of the trip and all other pertinent information relating to the trip (see Section A.4 of this Attachment). The CONTRACTOR may develop additional scripts for other types of NEMT calls from members, healthcare providers, and NEMT providers. Any script for use with an enrollee shall be written at the sixth (6th) grade reading level and must be prior approved in writing by TENNCARE.

A.9.15 The CONTRACTOR shall advise callers that calls to the NEMT Call Center are monitored and recorded for quality assurance purposes.

A.9.16 The CONTRACTOR shall record a statistically valid sample of incoming and outgoing calls to/from the NEMT Call Center for quality control, program integrity and training purposes.

A.9.17 The CONTRACTOR shall monitor and audit at least one percent (1%) of calls of each NEMT Call Center staff member on a monthly basis. The CONTRACTOR shall develop a tool for auditing calls, which shall include components to be audited and the scoring methodology. The CONTRACTOR shall use this monitoring to identify problems or issues, for quality control, and for training purposes. The CONTRACTOR shall document and retain results of this monitoring and subsequent training.

A.9.18 The CONTRACTOR’s NEMT Call Center system shall be able to produce the reports specified in Section A.19 of this Attachment as well as on request and ad hoc reports that TENNCARE may request.
A.9.19 The CONTRACTOR shall analyze data collected from its NEMT Call Center system as necessary to perform quality improvement, fulfill the reporting and monitoring requirements of the Agreement, and ensure adequate resources and staffing.

A.9.20 Failure to comply with requirements regarding the NEMT Call Center may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.10 **NEMT MEMBER EDUCATION**

A.10.1 The CONTRACTOR shall develop materials to inform and educate members about NEMT services.

A.10.2 The materials shall include, but not be limited to, information regarding eligibility for NEMT services, what services are covered/not covered, and how to request NEMT services, including the number to call, applicable timeframes, the approval and scheduling process, the use of fixed route, Standing Orders, and No-Show policies.

A.10.3 All written materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.10.4 Prior to the start date of operations, as specified by TENNCARE, the CONTRACTOR shall mail member education materials to its members by first class mail and at the CONTRACTOR’s expense.

A.11 **NON-COMPLIANT MEMBERS**

A.11.1 The CONTRACTOR shall provide targeted education to members who do not comply with the CONTRACTOR’s policies and procedures regarding NEMT services. All member materials shall comply with Section 2.17 of the Agreement and must be prior approved in writing by TENNCARE.

A.11.2 The CONTRACTOR shall not take any action to sanction members who do not comply with the CONTRACTOR’s policies and procedures.

A.11.3 Members shall not be charged for No-Shows (as defined in Exhibit A of this Attachment). The CONTRACTOR shall monitor NEMT member No Shows and enforce the No Show Policy provided to them by TENNCARE. Probation periods for non-compliant members shall be enforced as described in the policy. Failure to administer this policy and adhere to the probation notice requirements schedule shall result in liquidated damages as described in Exhibit F of this Attachment XI.

A.12 **NEMT PROVIDER NETWORK**

A.12.1 The CONTRACTOR shall establish a network of qualified NEMT providers to provide covered NEMT services to meet the transportation needs of members. In
developing its network of qualified NEMT providers the CONTRACTOR shall comply with Section 2.11.1 of the Agreement.

A.12.2 The CONTRACTOR shall have sufficient NEMT providers in its network (numbers and types of vehicles and drivers) so that the failure of any NEMT provider to perform will not impede the ability of the CONTRACTOR to provide NEMT services in accordance with the requirements of the Agreement.

A.12.3 The CONTRACTOR shall ensure that its NEMT providers have a sufficient number of vehicles and drivers available to meet the timeliness requirements of the Agreement (see Section A.5 of this Attachment).

A.12.4 The CONTRACTOR shall provide Human Resource Agencies (HRAs) the opportunity to become a NEMT provider if the HRA is qualified to provide the service and agrees to the terms of the CONTRACTOR’s NEMT provider agreement, which shall be no more restrictive than for other NEMT providers and include alternative indemnification language as specified in Section A.13.4 of this Attachment.

A.12.5 Notwithstanding an adequate network of providers or anything in this Agreement to the contrary, the CONTRACTOR shall provide Department of Intellectual and Developmental Disabilities (DIDD) residential and day service waiver providers the opportunity to become a NEMT provider if the provider is qualified to provide DIDD waiver transportation services (either as an individual transportation service or as a component of residential and/or day services) pursuant to provider qualifications applicable for such providers which shall be determined by DIDD. These providers shall only provide covered NEMT services to members receiving HCBS DIDD waiver services from the provider. The CONTRACTOR shall reimburse these providers for covered NEMT to TENNCARE covered services (see definition in Exhibit A) and shall not reimburse these providers for NEMT to services provided though a HCBS DIDD waiver. The CONTRACTOR shall reimburse these providers in accordance with rates paid to other NEMT providers for the provision of NEMT services.

A.12.6 The CONTRACTOR shall ensure that its NEMT providers are qualified to perform their duties. Except as specified in A.12.5, this includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Failure to comply with requirements regarding licensure requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.12.7 The CONTRACTOR’s NEMT provider network must be prior approved in writing by TENNCARE and shall be subject to ongoing review and approval by TENNCARE. Failure to comply with NEMT provider network requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.13 NEMT PROVIDER AGREEMENTS

A.13.1 All NEMT provider agreements shall comply with applicable requirements of the
Agreement, including but not limited to prior written approval of template agreements and revisions thereto by the Tennessee Department of Commerce and Insurance (TDCI).

A.13.2 Except for fixed route, NEMT providers used for contingency or back-up (see Section A.5.9 of this Attachment), or as otherwise agreed to by TENNCARE in writing, the CONTRACTOR shall not use transportation providers with which the CONTRACTOR has not executed a provider agreement.

A.13.3 In addition to the requirements in other sections of the Agreement, all NEMT provider agreements shall meet the following minimum requirements:

A.13.3.1 Include provisions related to payment for cancellations (see Section A.5.5.5 of this Attachment), no-shows (as defined in Exhibit A to this Attachment), escorts, and adults accompanying members under age eighteen (18);

A.13.3.2 Specify the services to be provided by the NEMT provider, including, as applicable, mode(s) of transportation and dispatching.

A.13.3.3 Include expectations for door-to-door, hand-to-hand, and curb-to-curb service (see Section A.4.4 of this Attachment and definitions in Exhibit A of this Attachment);

A.13.3.4 Include or reference trip manifest requirements (see Section A.5.5 of this Attachment);

A.13.3.5 Include urgent trip requirements (see Section A.5.7 of this Attachment);

A.13.3.6 Include or reference back-up service requirements (see Section A.5.9 of this Attachment);

A.13.3.7 Include or reference pick-up and delivery standards (see Section A.6 of this Attachment);

A.13.3.8 Require the NEMT provider to notify the CONTRACTOR of specified events, including no-shows (see Section A.6.2 of this Attachment), accidents, moving traffic violations, and incidents (see Section A.6.9 of this Attachment);

A.13.3.9 Require the NEMT provider to comply with all of the CONTRACTOR’s NEMT policies and procedures, including but not limited to those policies regarding No-Shows.

A.13.3.10 Include or reference vehicle standards (see Section A.7 of this Attachment);

A.13.3.11 Require the NEMT provider to notify the CONTRACTOR if a vehicle
is out of service or otherwise unavailable;

A.13.3.12 Include or reference training requirements for the NEMT provider (see Section A.16.2 of this Attachment) and for drivers (see Section A.8.2 of this Attachment);

A.13.3.13 Include or reference driver standards (see Section A.8.3), including driver log requirements (see Section A.8.3.15 of this Attachment) and require the NEMT provider to provide copies of driver logs to the CONTRACTOR upon request; and

A.13.3.14 Require the NEMT provider to secure and maintain adequate insurance coverage prior to providing any NEMT services under the Agreement, including, at minimum, the following:

A.13.3.14.1 Workers’ Compensation/ Employers’ Liability (including all states coverage) with a limit not less than the relevant statutory amount or one million dollars ($1,000,000) per occurrence for employers’ liability whichever is greater;

A.13.3.14.2 Comprehensive Commercial General Liability (including personal injury and property damage, premises/operations, independent contractor, contractual liability and completed operations/products) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) in the aggregate; and

A.13.3.14.3 Automobile Coverage (including owned, leased, hired, and non-owned vehicles) with a bodily injury/property damage combined single limit not less than one million dollars ($1,000,000) per occurrence.

A.13.4 If the CONTRACTOR has a provider agreement with a HRA, the agreement shall meet the requirements specified in Sections A.13.1 and A.13.3 above and shall also include indemnification language negotiated with the HRA and prior approved in writing by TENNCARE as an alternative to the indemnification language referenced in the Agreement.

A.13.5 The CONTRACTOR shall develop and implement, subject to prior approval by TENNCARE, a template provider agreement specifically for DIDC waiver residential or day services provider which reflects only those NEMT requirements that are applicable to such providers, as may be further clarified by TENNCARE in policy or protocol.

A.13.6 Failure to comply with provider agreement requirements may result in liquidated damages as provided in Section 4.20.2 of the Agreement.

A.14 PAYMENT FOR NEMT SERVICES
A.14.1 General

In addition to requirements in the Agreement regarding payment for services, when paying for NEMT services the CONTRACTOR shall comply with the requirements in this Attachment. In addition to the requirements of this Agreement and this Attachment, the CONTRACTOR shall have a policy to address fuel price adjustments.

A.14.2 Payment for Fixed Route

A.14.2.1 The CONTRACTOR shall make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.

A.14.2.2 If the CONTRACTOR cannot provide tickets/token/passes prior to the scheduled transportation, the CONTRACTOR shall offer the member the choice of having the CONTRACTOR arrange alternate transportation or reimbursing the member for the cost of the applicable fare for the fixed route transportation approved by the CONTRACTOR.

A.14.2.3 The CONTRACTOR may negotiate agreements with fixed route transportation entities. Such agreements must be prior approved in writing by TENNCARE.

A.14.3 Validation Checks

A.14.3.1 The CONTRACTOR shall conduct post validation checks by matching NEMT billed claims to Healthcare provider billed claims validating two percent (2%) of NEMT claims received in a month and if the CONTRACTOR determines that transportation for a particular member was not to a TennCare covered service, the CONTRACTOR validates the next three (3) requests for that member before approving the requested trip (see Section A.4.6 of this Attachment)). If the CONTRACTOR suspects fraud or abuse, it shall comply with the fraud and abuse requirements of the Agreement. The CONTRACTOR may exclude services when conducting post-validation in which billing of those services as appropriate (e.g. Pre-natal visits) cannot be validated in the required timeframe.

A.14.3.2 The CONTRACTOR shall perform post-transportation validation checks for fixed route transportation as specified in the CONTRACTOR’s policies and procedures, which must be prior approved in writing by TENNCARE.

A.15 NEMT CLAIMS MANAGEMENT

A.15.1 The CONTRACTOR shall process NEMT provider claims consistent with the
claims management requirements of the Agreement.

A.15.2 The CONTRACTOR shall submit encounter data for NEMT services that meets the requirements in the Agreement, including compliance with HIPAA’s electronic transactions and code set requirements.

A.15.3 The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for NEMT services delivered to a member are processed within thirty (30) calendar days of the receipt of such claims.

A.15.4 The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all NEMT provider claims for covered NEMT services delivered to a member.

A.15.5 The CONTRACTOR shall pay ninety-seven percent (97%) of NEMT claims accurately upon initial submission.

A.15.6 The CONTRACTOR shall conduct an audit of NEMT claims that complies with the requirements in the Agreement regarding a claims payment accuracy audit.

A.15.7 Failure to comply with requirements regarding NEMT claims management may result in liquidated damages as provided in Section 4.20.2 of the Agreement, Section A.20 of this Attachment, and/or Exhibit F of this Attachment.

A.16 NEMT PROVIDER MANUAL AND NEMT PROVIDER EDUCATION AND TRAINING

A.16.1 NEMT Provider Manual

A.16.1.1 The CONTRACTOR shall issue a NEMT provider manual to all NEMT providers. The CONTRACTOR may distribute the NEMT provider manual electronically (e.g., through its website) so long as NEMT providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the NEMT provider.

A.16.1.2 The NEMT provider manual must be prior approved in writing by TENNCARE and shall include, at a minimum, the following:

A.16.1.2.1 Description of the TennCare program;

A.16.1.2.2 Covered and non-covered NEMT services, including requirement that transportation must be to a TennCare covered service;

A.16.1.2.3 Prior approval requirements;

A.16.1.2.4 Vehicle requirements;

A.16.1.2.5 Driver requirements;
A.16.1.2.6 Protocol for encounter data elements reporting/records;

A.16.1.2.7 Claims submission protocols and standards, including instructions and all information necessary for a clean claim;

A.16.1.2.8 Payment policies;

A.16.1.2.9 Information on members’ appeal rights;

A.16.1.2.10 Member rights and responsibilities;

A.16.1.2.11 Policies and procedures of the provider grievance system; and

A.16.1.2.12 Important phone numbers of all departments/staff a NEMT provider may need to reach at the CONTRACTOR’s MCO.

A.16.1.3 The CONTRACTOR shall disseminate bulletins to NEMT providers as needed to incorporate any needed changes to the provider manual.

A.16.2 NEMT Provider Education and Training

A.16.2.1 The CONTRACTOR shall develop and implement a plan to educate NEMT providers, including initial orientation sessions and continuing education. The initial orientation shall include at minimum the topics included in the NEMT provider manual.

A.16.2.2 The CONTRACTOR shall ensure that all NEMT provider staff, including but not limited to dispatchers, supervisors, and mechanics, receive appropriate training before providing services under the Agreement and on an ongoing basis thereafter.

A.17 NEMT QUALITY ASSURANCE AND MONITORING

A.17.1 NEMT Quality Assurance Program

A.17.1.1 As part of the CONTRACTOR’s QM/QI program required by the Agreement, the CONTRACTOR shall develop and implement a quality assurance program for NEMT services. The description of the program (the NEMT Quality Assurance Plan) shall include policies and procedures outlining the objectives and scope of the program as well as activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of NEMT services.

A.17.1.2 The NEMT Quality Assurance Plan shall include at least the following:

A.17.1.2.1 The CONTRACTOR’s procedures for monitoring and improving member satisfaction with NEMT services;
A.17.1.2.2 The CONTRACTOR’s procedures for ensuring that all NEMT services paid for are properly approved and actually rendered, including but not limited to validation checks (see Sections A.4.6 and A.14.3) and an annual analysis matching physical health and behavioral health claims/encounters and NEMT claims/encounters;

A.17.1.2.3 The CONTRACTOR’s procedures for monitoring and improving the quality of transportation provided pursuant to the Agreement, including transportation provided by fixed route; and

A.17.1.2.4 The CONTRACTOR’s monitoring plan for NEMT providers, as detailed in Section A.17.3 of this Attachment.

A.17.2 Accidents and Incidents

The CONTRACTOR shall document accidents and incidents that occur while services are being delivered under the Agreement. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the trip, causing the driver to stop the vehicle, such as a passenger being unruly or ill.

A.17.3 NEMT Provider Monitoring Plan

A.17.3.1 The CONTRACTOR shall develop and implement a plan for monitoring NEMT providers’ compliance with all applicable local, state and federal law. The plan shall also monitor NEMT providers’ compliance with the terms of their provider agreements and all NEMT provider-related requirements of the Agreement, including but not limited to driver requirements, vehicle requirements, member grievance resolution requirements, and the delivery of courteous, safe, timely and efficient transportation services.

A.17.3.2 Monitoring activities shall include, but are not limited to:

A.17.3.2.1 On-street observations;

A.17.3.2.2 Random audits of NEMT providers;

A.17.3.2.3 Accident and incident reporting;

A.17.3.2.4 Statistical reporting of trips;

A.17.3.2.5 Analysis of grievances;

A.17.3.2.6 Driver licensure, driving record, experience and training;

A.17.3.2.7 Enrollee safety;

A.17.3.2.8 Enrollee assistance;
A.17.3.2.9 Completion of driver trip logs;
A.17.3.2.10 Driver communication with dispatcher; and
A.17.3.2.11 Routine scheduled vehicle inspections and maintenance.

A.17.4 NEMT Provider Corrective Action

A.17.4.1 The CONTRACTOR shall have policies and procedures for ensuring that an appropriate corrective action is taken when a NEMT provider furnishes inappropriate or substandard services, when a NEMT provider does not furnish services that should have been furnished, or when a NEMT provider is out of compliance with federal, state, or local law. The CONTRACTOR shall provide notification of the corrective action initiated between the CONTRACTOR and their NEMT provider as they occur.

A.17.4.2 The CONTRACTOR shall immediately remove from service any vehicle, driver, or EMT found to be out of compliance with the requirements of the Agreement, including any federal, state or local law. The vehicle, driver, or EMT may be returned to service only after the CONTRACTOR verifies that the deficiencies have been corrected. Any deficiencies, and actions taken to remedy deficiencies, shall be documented and become a part of the vehicle’s and/or the person’s permanent records.

A.17.4.3 As required in Section A.19.5.7 of this Attachment, the CONTRACTOR shall report on monitoring activities, monitoring findings, corrective actions taken, and improvements made.

A.17.5 NEMT Member Satisfaction Survey

A.17.5.1 The CONTRACTOR shall conduct a member satisfaction survey regarding NEMT services for the first six (6) months after the start date of operations or as otherwise specified by TENNCARE and annually thereafter.

A.17.5.2 The purpose of the survey is to verify the availability, appropriateness and timeliness of the trips provided and the manner in which the CONTRACTOR’s staff and the NEMT provider’s staff interacted with members.

A.17.5.3 The survey topics shall include, but are not limited to:
A.17.5.3.1 NEMT Call Center interaction;
A.17.5.3.2 Confirmation of scheduled trip;
A.17.5.3.3 Driver and CONTRACTOR staff courtesy;
A.17.5.3.4 Driver assistance, when required;
A.17.5.3.5 Overall driver behavior;
A.17.5.3.6 Driver safety and operation of the vehicle;
A.17.5.3.7 Condition, comfort and convenience of the vehicle; and
A.17.5.3.8 Punctuality of service.

A.17.5.4 The format, sampling strategies and questions of the survey must be
prior approved in writing by TENNCARE, and TENNCARE may
specify questions that are to appear in the survey.

A.17.5.5 The CONTRACTOR shall submit reports regarding these surveys as
required in Section A.19.5.8 of this Attachment.

A.17.6 Vehicle Inspection

A.17.6.1 The CONTRACTOR shall conduct a comprehensive inspection of all
NEMT providers’ vehicles prior to the implementation of NEMT
requirements in this Attachment. Thereafter, the CONTRACTOR shall
conduct a comprehensive inspection of all vehicles at least annually.
The CONTRACTOR is not required to inspect fixed route vehicles,
invalid vehicles, ambulances, DIDD residential or day service vehicles
enrolled to provide NEMT for the waiver participants they serve, or
vehicles for NEMT providers with which the CONTRACTOR does
not have a provider agreement (see Section A.13.2 of this
Attachment).

A.17.6.2 The CONTRACTOR shall develop and implement policies and
procedures for vehicle inspections. These policies and procedures must
be prior approved in writing by TENNCARE and shall include
inspection forms, inspection stickers and a list of trained inspectors,
including the names of all employees or subcontractors who are
authorized to inspect vehicles for the CONTRACTOR. Inspection
forms shall have a checklist that includes all the applicable vehicle
standards of the Agreement and of local, state and federal law. The
CONTRACTOR shall test all communication equipment during all
vehicle inspections.

A.17.6.3 Upon completion of a successful inspection, an inspection sticker shall
be applied to the vehicle. The inspection sticker shall be placed on the
outside of the passenger side rear window in the lower right corner.
The sticker shall state the license plate number and vehicle
identification number of the vehicle. Records of all inspections shall
be maintained by the CONTRACTOR.
A.18  **NEMT SUBCONTRACTS**

If the CONTRACTOR delegates any of its responsibilities regarding NEMT services, it shall comply with the subcontracting requirements in the Agreement, including prior written approval of the subcontract by TENNCARE.

A.19  **NEMT REPORTING**

A.19.1  **Approval and Utilization Reports**

A.19.1.1  **Approval Report.** The CONTRACTOR shall submit a quarterly approval report that summarizes transportation requested, approved, modified and denied, including the modification and denial reason. The report shall provide this information by month and mode of transportation.

A.19.1.2  **Pick-up and Delivery Standards Report.** The CONTRACTOR shall submit a monthly report that documents the scheduled pick-up time, actual pick-up time, members appointment time, time the member was dropped off for the appointment, pre-aranged return pick-up time, time the member requested pick-up (if not pre-aranged), actual return pick-up time and time the member arrived at their final destination.

A.19.1.3  **Drug and Alcohol Testing Report.** The CONTRACTOR shall submit a quarterly report providing a listing of drivers who have been drug and alcohol tested during the reporting period. A minimum of five percent (5%) of drivers should be reported each quarter. The report shall include, at a minimum, the name of the driver tested for drugs and alcohol, name of the provider that the driver is contracted with, social security number of the driver, date the driver was authorized to transport, and the date the test was conducted. Drivers’ drug and alcohol test should be current within the last five (5) years.

A.19.1.4  **Utilization Report.** The CONTRACTOR shall submit a monthly utilization report that provides a summary of information on NEMT services provided to members. The report shall include, at minimum, by mode of transportation: the number of trips, number of unduplicated members, and number of miles.

A.19.1.5  **No-Show Report.** The CONTRACTOR shall submit a monthly no-show utilizing the template provided by TENNCARE.

A.19.2  **NEMT Call Center Reports**

A.19.2.1  The CONTRACTOR shall submit a monthly report that provides summary and detail statistics on the NEMT Call Center telephone lines/queues and includes calls received, calls answered, total calls received during regular business hours and total calls received after
business hours.

A.19.2.2 The CONTRACTOR shall submit a monthly report listing the name, position title and the identification code for all members of the call center staff.

A.19.3 NEMT Provider Enrollment File

The CONTRACTOR’s monthly provider enrollment file shall include NEMT providers. In addition, the CONTRACTOR shall provide the following information to TENNCARE within timeframes described below:

A.19.3.1 Driver Roster. The CONTRACTOR shall provide a monthly driver roster for each NEMT provider that includes, at minimum: the driver’s name, license number, and social security number.

A.19.3.2 Vehicle Listing. The CONTRACTOR shall provide a monthly vehicle listing for each NEMT provider that includes, at minimum: the type of vehicle and the vehicle’s manufacturer, model, model year, and vehicle identification number.

A.19.3.3 NEMT Provider Listing. The CONTRACTOR shall provide a monthly provider listing, identifying the providers utilized during the reporting period listing the name, whether the provider is a participating or non-participating provider, mode of transportation and the county and state of the pick-up location. This report shall give the number of participating and non-participating providers as well as a grand total of all NEMT providers.

A.19.4 NEMT Claims Management Reports

A.19.4.1 The CONTRACTOR shall submit a monthly NEMT prompt payment report. The report shall include the number and percentage of clean NEMT claims that are processed within thirty (30) calendar days of receipt, the number and percentage of NEMT claims that are processed within sixty (60) calendar days of receipt, the number and percentage of NEMT claims and the dollar value and percentage of dollars associated with claims that are processed within the timeframes specified by TENNCARE (e.g., fifteen (15) days, thirty (30) days, etc.), and the average time (number of days) that it takes to process NEMT claims.

A.19.4.2 The CONTRACTOR shall submit a monthly NEMT claims payment accuracy report. The report shall be based on an audit conducted by the CONTRACTOR in accordance with Section 2.22.6 of the Agreement using a random sample of all “processed or paid” NEMT claims. The report shall include the number and percentage of NEMT claims that are paid accurately for each month.
A.19.5 NEMT Quality Assurance and Monitoring Reports

A.19.5.1 Member NEMT Grievance Report. The CONTRACTOR shall submit a monthly member grievances report (see Section 1 of the Agreement for the definition of grievance, which includes both written and verbal statements) that details the date which the grievance was reported, the date the issue occurred, who reported the grievance, the members name, transportation provider, grievance details, date of resolution and detail of the resolution. This report shall detail grievances received about the NEMT provider.

A.19.5.2 NEMT Provider Grievance Report. The CONTRACTOR shall submit a monthly NEMT provider grievances report that details the number of verbal and written grievances from the transportation provider about a member.

A.19.5.3 NEMT Quality Assurance Plan. As part of its annual QM/QI reporting required by the Agreement, the CONTRACTOR shall submit an annual NEMT quality assurance plan (see Section A.17.1 of this Attachment).

A.19.5.4 NEMT Validation Checks.

A.19.5.4.1 The CONTRACTOR shall submit a quarterly report summarizing the pre-transportation validation checks (see Section A.4.6 of this Attachment) conducted by the CONTRACTOR,

A.19.5.4.2 The CONTRACTOR shall submit a quarterly report summarizing the post-transportation validation checks (see Section A.14.3 of this Attachment) conducted by the CONTRACTOR,

A.19.5.5 Post-Payment Review Report. The CONTRACTOR shall submit an annual report summarizing the methods and findings for the post-payment review (see Section A.17.1.2.2 of this Attachment) and identifying opportunities for improvement.

A.19.5.6 Accidents and Incidents.

A.19.5.6.1 Immediately upon the CONTRACTOR or the subcontracted vendor becoming aware of any accident resulting in driver or passenger injury or fatality or incidents involving abuse or alleged abuse by the driver that occurs while providing services under the Agreement, the CONTRACTOR shall notify TENNCARE. The CONTRACTOR shall submit a written accident/incident report within five (5) business days of the accident/incident and shall cooperate in any related investigation. A police report shall be included in the accident/incident report or provided as soon as possible.
A.19.5.6.2 The CONTRACTOR shall submit a monthly report of all accidents, moving traffic violations, and incidents.

A.19.5.6.3 Failure by the CONTRACTOR to comply with Section A.19.5.6 shall result in the application of liquidated damages as described in Exhibit F.

A.19.5.7 Monitoring Plan.

A.19.5.7.1 The CONTRACTOR shall submit an annual NEMT provider monitoring plan (see Section A.17.3 of this Attachment).

A.19.5.7.2 The CONTRACTOR shall submit an annual report summarizing its monitoring activities, the findings, corrective actions, and improvements for NEMT services provided under the Agreement.

A.19.5.8 Satisfaction Survey Report. The CONTRACTOR shall submit a report (three months after the initial survey period and then annually) summarizing the member survey methods and findings and identifying opportunities for improvement.

A.20 Performance Standards

The CONTRACTOR agrees that TENNCARE may assess liquidated damages against the CONTRACTOR for failure to meet the performance standards as specified in Exhibit F of this Attachment.
The terms used in this Attachment shall be given the meaning used in TennCare rules and regulations. However, the following terms, when used in this Attachment, shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

**Definitions**

1. **Commercial Carrier Transport**: Transportation provided by a common carrier, including but not limited to buses (e.g., Greyhound), trains (e.g., Amtrak), airplanes, and ferries.

2. **Curb-to-Curb Service**: Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the enrollee’s needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any enrollee. The driver shall remain at or near the vehicle and not enter any buildings.

3. **Door-to-Door Service**: Transportation provided to enrollees with disabilities who need assistance to safely move between the door of the vehicle and the door of the passenger’s pick-up point or destination. The driver shall exit the vehicle and assist the enrollee from the door of the pick-up point, e.g., residence, accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the enrollee throughout the transport and to the door of the destination.

4. **Federal Motor Carrier Safety Administration (FMCSA)**: A separate administration within the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.

5. **Fixed Route**: Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.

6. **Hand-to-Hand Service**: Transportation of an enrollee with disabilities from an individual at the pickup point to a provider staff member, family member or other responsible party at the destination.

7. **Hospital Discharge**: Notification by a hospital that an enrollee is ready for discharge. A hospital discharge shall be considered an urgent trip.

8. **HRAs**: Human Resource Agencies. These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of
Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA, Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.

9. **No-Show:** A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member cancels at the door or is not present five (5) minutes after the scheduled pick-up time.

10. **Non-Urban Trip:** Covered NEMT service not within a city and considered less populated, (rural as described by the US Census Bureau).

11. **Private Automobile:** An enrollee’s personal vehicle or the personal vehicle of a family member or friend, to which the enrollee has access.

12. **Single Trip:** Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

13. **Standing Order:** Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same enrollee with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).

14. **TennCare Covered Services:** The health care services available to TennCare enrollees, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, dental services, and institutional services. TennCare covered services includes TennCare Kids services. For purposes of NEMT, TennCare covered services does not include CHOICES HCBS or 1915(c) MR waiver services.

15. **Tennessee Department of Intellectual and Developmental Disabilities (DIDD):** The state agency responsible for providing services and supports to Tennesseans with intellectual and developmental disabilities. DIDD is a division of the Tennessee Department of Finance and Administration.

16. **Trip Leg:** One-way transport from a pick-up point to a destination. A trip generally has at least two (2) trip legs.

17. **Urban Trip:** Covered NEMT service within a city or a more populated area (not rural as described by the US Census Bureau)

18. **Urgent Trip:** Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). At a minimum, these shall be considered urgent trips: Hospital and Crisis Stabilization Unit discharges and same-day appointments with outpatient behavioral health providers.
Exhibit B
TRIP MANIFESTS

The trip manifests supplied to NEMT providers shall include all necessary information for the driver to perform the trip for each enrollee, including but not limited to:

1. Number assigned by the CONTRACTOR for approved trip;
2. NEMT provider name;
3. The mode of transportation;
4. MCO;
5. Enrollee’s name;
6. Enrollee’s age;
7. Enrollee’s sex;
8. Trip date;
9. Number of legs for the trip (e.g., one-way, round trip, or multiple legs);
10. Origin of trip/place of pick-up (e.g., residence)
11. Time of pick-up for the time zone applicable to the pick-up location;
12. Address of the pick-up, including street address, city, county, state, and zip code;
13. Enrollee’s phone number(s);
14. Number of riders;
15. Time of appointment for the time zone applicable to the appointment location;
16. Provider name;
17. Address of the provider, including street address, city, county, state, and zip code;
18. Provider’s phone number(s);
19. Return trip times for the applicable time zone(s) and addresses, if applicable;
20. Any additional stops (e.g., pharmacy);
21. Any special needs of the enrollee;
22. Any special instructions to the driver, e.g., door-to-door or hand-to-hand service;
23. Whether enrollee has third party coverage, including Medicare; and

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR’s subcontractors, NEMT providers and drivers.
Exhibit C

VEHICLE REQUIREMENTS

All vehicles, except for fixed route vehicles and ambulances, shall meet the following requirements:

1. The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer’s approved seating capacity.

2. All vehicles shall have adequately functioning heating and air-conditioning systems.

3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position. All vehicles shall have an easily visible interior sign that states: “ALL PASSENGERS SHALL USE SEAT BELTS”. Seat belts shall be stored off the floor when not in use.

4. Each vehicle shall use child safety seats in accordance with state law.

5. All vehicles shall have at least two (2) seat belt extensions.

6. For use in emergency situations, each vehicle shall be equipped with at least one (1) seat belt cutter that is kept within easy reach of the driver.

7. All vehicles shall have functioning interior light(s) within the passenger compartment.

8. All vehicles shall have an accurate, operating speedometer and odometer.

9. All vehicles shall have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.

10. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.

11. The exterior of all vehicles shall be clean and free of broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicles.

12. The interior of all vehicles shall be clean and free of torn upholstery, floor or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items.

13. All vehicles shall be smooth riding, so as not to create passenger discomfort.

14. All vehicles shall have the NEMT provider’s business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background.

15. To comply with confidentiality requirements, no words may be displayed on the vehicle that implies that TennCare enrollees are being transported. The name of the NEMT provider’s business may not imply that TennCare enrollees are being transported.
16. The vehicle license number and the CONTRACTOR’s toll-free phone number shall be prominently displayed on the interior of each vehicle. This information and the grievance procedures shall be clearly visible and available in written format (at a minimum, in English and Spanish) in each vehicle for distribution to enrollees upon request.

17. The vehicle shall have a current inspection sticker issued by the CONTRACTOR on the outside of the passenger side rear window in the lower right corner.

18. Smoking shall be prohibited in all vehicles at all times. All vehicles shall have an easily visible interior sign that states: “NO SMOKING”.

19. All vehicles shall carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.

20. All vehicles shall be equipped with a first aid kit stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash.

21. Each vehicle shall contain a current map of the applicable geographic area with sufficient detail to locate enrollee and provider addresses.

22. Each vehicle shall be equipped with a regulation size Class B chemical type fire extinguisher. The fire extinguisher shall have a visible, current (up-to-date) inspection tag or sticker showing an inspection of the fire extinguisher by the appropriate authority within the past twelve (12) months. The extinguisher shall be mounted in a bracket located in the driver’s compartment and be readily accessible to the driver and passenger(s).

23. Each vehicle shall be equipped with a “spill kit” that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.

24. Each vehicle shall be equipped with emergency triangles.

25. Each vehicle that is required to stop at all railroad crossings shall have a railroad crossing decal that says that the vehicle stops at all railroad crossings.

26. Each vehicle shall have a real-time link, telephone or two-way radio. Pagers are not acceptable as a substitute.
Exhibit D

DRIVER REQUIREMENTS

The requirements listed below shall apply to all drivers of vehicles other than fixed route vehicles and ambulances.

1. All drivers shall be courteous, patient, and helpful to all passengers.

2. All drivers shall be neat and clean in appearance.

3. No driver shall use alcohol, narcotics, illegal drugs or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.

4. All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.

5. No driver shall smoke or eat while in the vehicle, while assisting an enrollee, or in the presence of any enrollee.

6. Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or the CONTRACTOR.

7. Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.

8. The driver shall provide an appropriate level of assistance to an enrollee when requested or when necessitated by the enrollee’s mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.

9. The driver shall assist enrollees in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.

10. The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.

11. Upon arrival at the destination, the driver shall park the vehicle so that the enrollee does not have to cross streets to reach the entrance of the destination.

12. Drivers shall visually confirm that the enrollee is inside the destination.

13. The driver shall not leave an enrollee unattended at any time.
14. If an enrollee or other passenger’s behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.
The CONTRACTOR shall require that the NEMT providers’ drivers maintain daily transportation logs containing, at a minimum, the information listed below. Fixed route transportation is excluded from this requirement.

1. Date of service;
2. Driver’s name;
3. Driver’s signature;
4. Name of escort or accompanying adult (for enrollees under age eighteen (18) and relationship to enrollee (if applicable);
5. Vehicle Identification Number (VIN);
6. Enrollee’s name;
7. The NEMT provider’s name;
8. Number assigned by the CONTRACTOR for the approved trip;
9. Mode of transportation approved;
10. Actual start time (from the base station) for the time zone applicable to the starting location;
11. Scheduled pick-up time for the time zone applicable to the pick-up location;
12. Actual pick-up location and time for the time zone applicable to the pick-up location;
13. Actual departure time from pick-up location for the time zone applicable to the pick-up location;
14. Actual destination and time for the time zone applicable to the destination;
15. Actual number of wheelchairs, escorts, and accompanying adults (for enrollees under age eighteen (18));
16. Odometer readings at each point of pick-up and of drop-off; and
17. Notes, if applicable. At a minimum, the log shall show notes in the case of cancellations, incomplete requests, “no-shows”, accident and incident.

For ambulance, the log shall also contain, at a minimum:

1. Patient assessment by ambulance personnel and a chronological narrative of care/service rendered by ambulance personnel;
2. Itemized list of specialized services and/or supplies; and
3. Type of vehicle used for transport (class or service category).

The CONTRACTOR may express time in regular time (AM or PM) or in military time (using the 24-hour clock); however, the selected method for expressing time (regular or military) shall be used consistently by the CONTRACTOR and by all of the CONTRACTOR’s subcontractors, NEMT providers and drivers.
<table>
<thead>
<tr>
<th>No.</th>
<th>PERFORMANCE STANDARD</th>
<th>LIQUIDATED DAMAGE</th>
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<tbody>
<tr>
<td>1</td>
<td>Ensure that members receive the appropriate level of service (see Section A.4.4 of this Attachment)</td>
<td>$500 per deficiency</td>
</tr>
<tr>
<td>2</td>
<td>Comply with the approval and scheduling timeframes (see Section A.5.1.4 of this Attachment)</td>
<td>$1,000 per deficiency</td>
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<tr>
<td>3</td>
<td>Comply with requirements regarding urgent trips (see Section A.5.7 of this Attachment)</td>
<td>$1,500 per deficiency</td>
</tr>
<tr>
<td>4</td>
<td>Comply with pick-up and delivery standards (see Section A.6 of this Attachment)</td>
<td>$500 per deficiency</td>
</tr>
<tr>
<td>5</td>
<td>Comply with vehicle standards (see Section A.7 of this Attachment)</td>
<td>$1,000 per calendar day per vehicle that is not in compliance with ADA requirements</td>
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<td>$1,000 per vehicle that is allowed into service without an inspection in accordance with the requirements of the Agreement</td>
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<td>$2,500 per calendar day per vehicle that is not in compliance with a vehicle standard that would endanger health or safety for vehicle occupants</td>
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<td>$500 per calendar day per vehicle that is not in compliance with a vehicle standard that creates passenger discomfort or inconvenience</td>
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<td>$100 per calendar day per vehicle that is not in compliance with an administrative vehicle standard</td>
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<td>6</td>
<td>Comply with driver training requirements and driver standards (see Section A.8 of this Attachment)</td>
<td>$2,500 per calendar day per driver for each calendar day that a driver is not in compliance with the driver standards</td>
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<td>The following sanctions are specifically for NEMT drivers.</td>
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<td>For the first deficiency: $5,000 for failure to meet the 5% requirement for drug and alcohol testing per quarter.</td>
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<td></td>
<td>For the second deficiency: $7,500 for failure to meet the 5% requirement for drug and alcohol testing per quarter.</td>
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<tr>
<td>Requirement</td>
<td>First Deficiency</td>
<td>Second Deficiency</td>
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<td>----------------------------------------------------------------------------</td>
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<tr>
<td>7 85% of all calls to the NEMT Call Center are answered by a live voice</td>
<td>$5,000 for each full percentage point below 85% per month per line/queue</td>
<td>$10,000 for each full percentage point below 85% per month per line/queue</td>
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<td>within thirty (30) seconds (see Section A.9 of this Attachment)</td>
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<tr>
<td>8 Less than 5% of calls to the NEMT Call Center are abandoned (see Section</td>
<td>$5,000 for each full percentage point above 5% per month per line/queue</td>
<td>$10,000 for each full percentage point above 5% per month per line/queue</td>
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<td>A.9 of this Attachment)</td>
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<tr>
<td>9 Average hold time for calls to the NEMT Call Center is no more than 3</td>
<td>$5,000 for each 10 seconds over 3 minutes per month per line/queue</td>
<td>$10,000 for each 10 seconds over 3 minutes per month per line/queue</td>
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<td>minutes (see Section A.9 of this Attachment)</td>
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<td>10 Process 90% of clean NEMT claims within thirty (30) calendar days of the</td>
<td>$10,000 for each month determined not to be in compliance</td>
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<td>receipt of the claim and process 99.5% of claims within sixty (60) calendar</td>
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<td>of receipt (see Section A.15.3 and Section A.15.4 of this Attachment)</td>
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<td>11 97% of NEMT claims are paid accurately upon initial submission (see Section</td>
<td>$5,000 for each full percentage point accuracy is below 97% for each reporting period.</td>
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<td>A.15.5 of this Attachment)</td>
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<td>Failure by the CONTRACTOR to notify TENNCARE of an Accident/Incident in accordance with Section A.19.5.6 of this Attachment</td>
<td>$1,000 per occurrence</td>
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<td>13</td>
<td>Failure by the CONTRACTOR to comply with pre-validation requirements and the post-validation requirements (See Section A.4.6 and Section A.14.3 of this Attachment XI)</td>
<td>$5,000 for failure to meet the 2% benchmark for pre-validations of NEMT scheduled trips</td>
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<td>$1,000 for failure to meet the 2% benchmark for post-validations of NEMT trips; and</td>
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<td>$100 per calendar day until an acceptable report has been received by TENNCARE beginning on the date the CONTRACTOR is notified of the deficiency</td>
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<tr>
<td>14</td>
<td>Failure by the Subcontractor to provide an acceptable Member Satisfaction Survey in accordance with the applicable section(s) of the CRA, summarizing the methods and findings identifying opportunities for improvement in NEMT Services (see Sections A.17.5 and A.19.5.8 of Attachment XI: NEMT Requirements in the CRA)</td>
<td>$2,500 for failure to provide an acceptable survey as required</td>
</tr>
<tr>
<td>15</td>
<td>Failure by the Subcontractor to enforce the Member No-Show Policy and adhere to the requirements of the policy provided by TENNCARE (see Section A.11.3 of Attachment XI: NEMT Requirements in the CRA)</td>
<td>$100 per occurrence for failure to follow the notification requirements of the No-Show Policy</td>
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<td>$100 per occurrence for failure to follow the probationary requirements of the No-Show Policy</td>
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<td>$100 per occurrence for failure to administer the No-Show Policy to a Non-Compliance Member reported to Subcontractor by a driver</td>
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</table>
In February 2013, the State of Tennessee launched the Tennessee Health Care Innovation Initiative, which seeks to pay for outcomes and quality care (i.e. value-based care), rather than for the amount of services provided (i.e. volume-based care). The state is working collaboratively with hospitals, medical providers, and payers to achieve meaningful payment reform. By working together, the state believes we can make significant progress towards sustainable medical trends and improving care.

The Tennessee Health Care Innovation Initiative has three strategies: primary care transformation, episodes of care, and long-term services and supports.

- **Primary care transformation** focuses on the role of the primary care Provider in promoting the delivery of preventive services and managing chronic illnesses over a continuum of time. The initiative is developing an aligned model for patient-centered medical homes (PCMH), health homes for Serious and Persistent Mental Illness, and hospital and emergency department (ED) admission/discharge/ transfer Provider alerts to be implemented statewide.

- **Episodes of care** focus on the health care delivered in association with acute health care events such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple Providers in relation to a specific health care event.

- **The long-term services and supports (LTSS)** component focuses on improving quality and shifting payment to outcomes-based measures for the QuILTSS program and for enhanced respiratory care.

This Provider Guide includes important information about the design of the program, focusing initially on the Episodes of Care strategy described above. This guide also offers resources to help health care Providers understand how the program impacts their organization.

The State of Tennessee and BlueCare Tennessee have developed websites specific to this effort as well.


BlueCare Tennessee: [http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html](http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html)
**Program Introduction:**

Tennessee Health Care Innovation Initiative Program


BlueCare Tennessee and other payers in this initiative produce quarterly reports for Principal Accountable Providers, a.k.a. “Quarterbacks”, with qualifying episodes that provide cost and quality performance information related to the episode(s). Reports from BlueCare Tennessee can be accessed via the Availity® secure portal. If you are a registered Provider, go to the Availity website [http://www.availity.com](http://www.availity.com/) login and scroll down to the “Applications” tab and use the “next” button until you find “THCII Reporting”. Select “BCBST” from the “Payer Spaces” menu then select “THCII Reporting”. If you are not registered, go to [http://Availity.com](http://Availity.com) and click on “Register” in the upper right corner of the home page, select “Providers”, click “Register” and follow the instructions in the Availity registration wizard. Included with these reports are helpful resources to better understand the reports. Additionally, we developed a Frequently Asked Questions (FAQ) document that provides answers to many of the commonly asked questions to Episodes of Care.

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<td>Episode of Care Waves Description and Code Summary</td>
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A detailed explanation of the risk adjustment methodology and Risk Factors and Weights used for the different episode of care waves is provided below. These documents are also available on the BlueCare Tennessee website in the Availity Provider portal along with the Provider reports for all qualifying episodes.

| BCBST Risk Adjustments | Tennessee Health Care Innovation Initiative Risk Adjustment Methodology | <http://bluecare.bcbst.com/forms/Provider%20Forms/Risk_Adjustment_Methodology_070516.pdf> |

BlueCare Tennessee and BlueCare, Independent Licensees of BlueCross BlueShield Association
BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

TN Health Care Innovation Initiative Guide – 10.31.17
An explanation of the “Acceptable” and “Commendable” threshold levels for each episode of care is provided below. The State of Tennessee established the “Acceptable” threshold levels and each payer participating in the Tennessee Health Care Innovation Initiative established its “Commendable” levels based on the criteria explained below.

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Information pertaining to Episode Thresholds can be found under Episodes of Care and Other Resources at the following link: [http://bluecare.bcbst.com/providers/quality-care/thcii.html](http://bluecare.bcbst.com/providers/quality-care/thcii.html).

Information pertaining to Quality Metrics can be found in the Detailed Business Requirements document written specifically for each Episode at the following link: [https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html](https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/episodes-by-wave.html).

A BlueCare Tennessee episode of care reporting and gain or risk payment will be calculated based on a contract entity identifier as explained below:

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|---|---|---|

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A BlueCare Tennessee reporting is aggregated using a combination of the Provider’s Contract ID and Tax ID based on how a Provider is contracted (i.e., individual, group, facility, health system, IPA, etc.).

Further, the combination of Contract ID and Tax ID impacts the State’s Tennessee Health Care Innovation Initiative episode of care gain and risk share payments. Since reporting is run by the combination of Contract ID and Tax ID, Provider’s episodes are also aggregated using the combination. BlueCare Tennessee will payout and recoup gain and risk share payments according to how the contracted entity/Provider is contracted as a whole under the Contract ID and Tax ID combination. BlueCare Tennessee does not split out payments to the entity, but will allow the contracted entity/Provider(s) to distribute as they determine.
**What is a Contract ID?**
A Contract ID is an internal BlueCross reference code that connects Providers who participate under the same core agreements for specific networks. Additional information about Contract IDs can be found here:

[http://bluecare.bcbst.com/forms/Provider%20Forms/THCII%20FAQ.pdf](http://bluecare.bcbst.com/forms/Provider%20Forms/THCII%20FAQ.pdf)

There are specific Lines of Business that were selected to participate in the Tennessee Health Care Innovation Initiative.

| Lines of Business affected | BlueCare, TennCareSelect, CoverKids |

**THCII Provider Dispute Resolution Procedure**
THCII Episode of Care Reports can be disputed with BlueCare Tennessee. It is important THCII participants review interim and performance reports quarterly. Please address any issues or concerns found in a preview or performance period report with your Network Manager and if escalation is necessary, through our dispute resolution process. Any questions related to claims data and quality measures should be directed first to the appropriate Network Manager. The Network Manager will engage a resolutions team that will work to reconcile issues. If these issues cannot be resolved, the Provider can then follow the THCII Provider Dispute Resolution Procedure. This procedure can be found on the BlueCare Tennessee Website at:

[http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html](http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html)

**Tennessee Department of Commerce and Insurance (TDCI) Formal Appeals Process**

TDCI’s existing process for providers appealing MCO’s payment will apply to episode value-based payments. This process should be utilized if BlueCare Tennessee is unable to address a provider’s complaint pertaining to the final gain or risk share amount presented to the Final Performance Report released in August. One element of TDCI’s Formal Appeals Process requires Providers to make one (1) attempt for reconsideration with MCO prior to utilizing this appeals process.

Providers may file a request in order to dispute their episode value-based payment with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve final performance period gain or risk share reported by BlueCare Tennessee, as provided in T.C.A. 56-32-126. It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-126.
The Request to Commissioner of Commerce for Independent Review of Disputed TennCare Claim form is located on the state’s website at <https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/forms/INDEPENDENT_REVIEW_EOC_FORM_111416.pdf>. Additional information regarding the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance are also online at https://www.tn.gov/commerce/tenncare-oversight/mco-dispute-resolution.html or by calling the State of Tennessee at (615) 741-2677.

*This Provider Guide is being included in the upcoming revisions to the BlueCare Tennessee Provider Administration Manual.*