

# Volunteer State Health Plan

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## CHOICES Long-Term Care 2010 Nursing Facilities



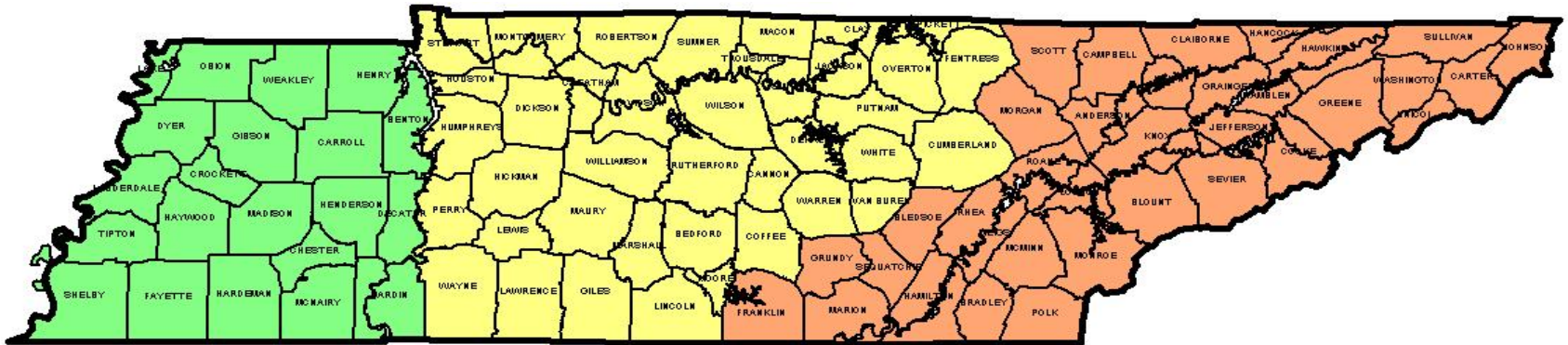
# Who We Are

- VSHP is a wholly-owned subsidiary of BlueCross BlueShield of Tennessee (BCBST)
- BCBST covers 2.4 million lives
  - Tennessee's oldest and largest insurer
- VSHP was the first TennCare Managed Care Organization (MCO) established in 1994
  - Administers BlueCare and *TennCareSelect*
  - Covers 500,000 lives statewide

# Mission Statement

“To be the national expert for state governments seeking innovative partners to develop health care solutions for the nation’s most vulnerable populations.”

# Grand Regions by MCO



<b><i>West Tennessee</i></b>	
AmeriChoice	Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, Weakley
BlueCare	
TennCareSelect	
<b><i>Middle Tennessee</i></b>	
AmeriChoice	Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson, Wilson
AmeriGroup	
TennCareSelect	
<b><i>East Tennessee</i></b>	
AmeriChoice	Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union, Washington
BlueCare	
TennCareSelect	

# What Happens When CHOICES Is Implemented?

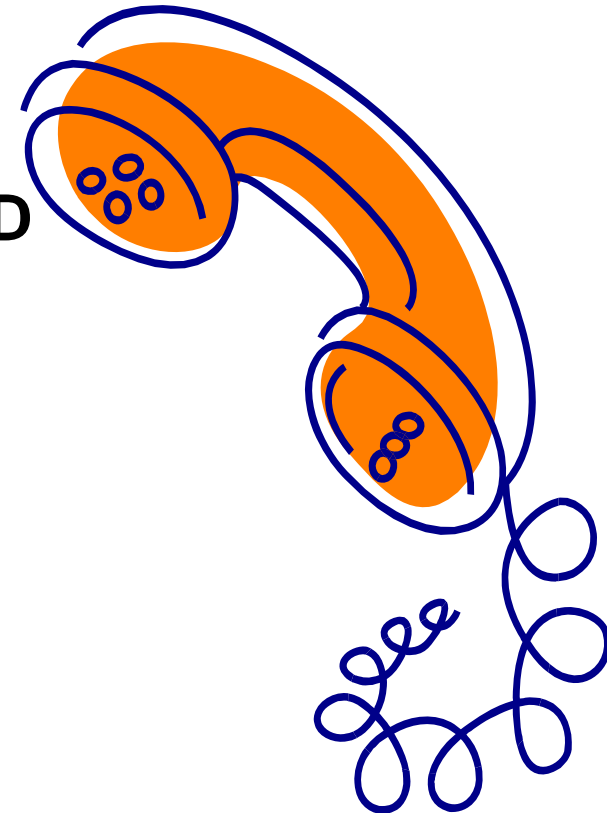
- Members receiving Nursing Facility (NF) care will continue to qualify for and receive NF care.
- Members will be able to stay in the NF where they currently reside, so long as the NF meets CMS conditions of participation.
- Members are transitioned into CHOICES
  - LTC Services are provided via CHOICES
  - LTC Services are NO LONGER provided via the current fee-for-service system
  - Payment will come from the MCOs

# Single Point of Entry (SPOE)

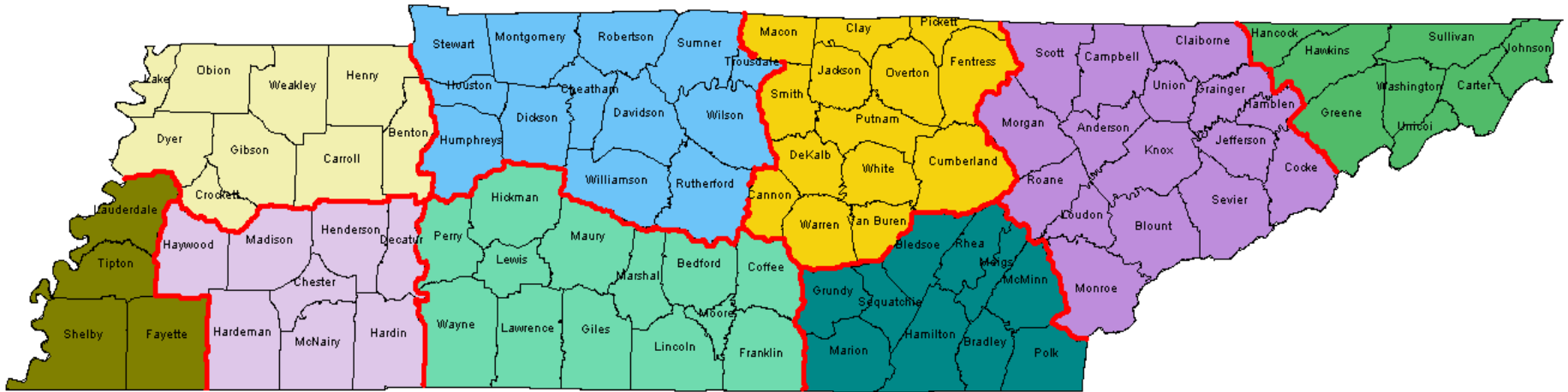
- Area Agencies on Aging and Disability (AAADs)
  - One access point for new Medicaid applicants seeking access to CHOICES services
  - Public Education and Outreach
  - Information and Referral
  - Screening and Assessment
  - Facilitate eligibility and enrollment
  - Completion and submission of Pre-Admission Evaluations (PAE)
  - Credentialing of Home and Community Based Services (HCBS) Providers

# AAAD/SPOE Toll-Free Number

- **For people who do not already have Medicaid, this is the number they may call to speak with someone who can tell them more about CHOICES.**
  - **1-866-836-6678**
  - **OR, they may call the local AAAD**



# Tennessee AAD's



Area	Name	Address	City	State	Zip	Phone	Fax
1	First TN Dev. District	207 North Boone Street Suite 800	Johnson City	TN	37604	423-928-0224	423-928-5209
2	East TN Human Resource Agency	9111 Cross Park Drive, Suite D100	Knoxville	TN	37923	865-691-2551 ext. 216	865-531-7216
3	Southeast TN Dev. District	1000 Riverfront Parkway	Chattanooga	TN	37402	423-266-5781	423-424-4225
4	Upper Cumberland Dev. District	1225 South Willow Ave.	Cookeville	TN	38506	931-432-4111	931-432-6010
5	Greater Nashville Regional Council	501 Union Street, 6th Floor	Nashville	TN	37219	615-862-8828	615-862-8840
6	South Central TN Dev. District	815 South Main Street	Columbia	TN	38402	931-381-2040	931-381-2053
7	Northwest Dev. District	124 Weldon Drive	Martin	TN	38237	731-587-4213	731-588-5833
8	Southwest TN Dev. District	27 Conrad Drive, Suite 150	Jackson	TN	38305	731-668-7112	731-668-6438
9	Aging Commission of the Mid-South	2670 Union Avenue Extended, Suite 1000	Memphis	TN	38112	901-324-6333	901-327-7755



# Care Coordination



# Care Coordination In CHOICES

- Comprehensive, continuous, holistic, and person-centered approach to care coordination
  - Help the member maintain or improve physical or behavioral health status or functional abilities
  - Maximize member independence
  - Ensure the member's health, safety and welfare
- Integrated model of coordination of care – medical as well as social
- Addresses physical, behavioral, functional (ADL) and psychosocial needs
- Coordinates ALL Medicaid services for the elderly and disabled – physical, behavioral and long-term care

# Transitioning NF Residents

- 30-day continuity of care period
  - Continue to receive NF services from current NF provider for at least 30 days (contract or non-contract)
  - Extended pending completion of face-to-face visit, any needs assessment and Plan of Care (POC) supplement deemed necessary
- MCO shall reimburse non-contract NF providers at **full contract rate** during Continuity of Care (COC) period, even if extended beyond 30 days until face-to-face visit/needs assessment/POC supplement is completed
- Face-to-face visit/needs assessment/POC supplement completed:
  - Within 90 days if member is in a NF for less than 90 days at implementation
  - Within 6 months if member is in a NF for 90 days or more at implementation

# Transitioning NF Residents (cont.)

- Members residing in a NF at implementation may be moved to another NF **only** when:
  - Member (or representative) requests to move (documentation required)
  - Member (or representative) provides written consent to move based on VSHP quality/other concerns
  - NF not contracted with VSHP, and only *after* minimum 30-day COC period and face-to-face visit/needs assessment/POC supplement complete, and **only with member's (or representative's) consent**
- 30-day COC period shall be extended to enroll NF provider or facilitate transition to contract NF based on member's (or representative's) consent
- Pursuant to *Linton*, member shall not be required to move out of NF that meets CMS conditions of participation
- Should member remain in non-contract NF beyond COC period, NF is reimbursed at non-contract rate *after* at least 30 days and completion of face-to-face visit

# Enhanced Nursing Facility Rates

- In addition to Level I and Level II NF rates (established by the Comptroller's Office), there will be three enhanced NF rates:
  - Vent Weaning (VW)
  - Chronic Ventilator Care (CV)
  - Tracheal Suctioning (TS)
- Medical necessity criteria for VW NF services will be managed by VSHP:
  - determines if services are medically necessary
  - authorizes the services for the appropriate period of time

# Enhanced NF Rates (cont.)

- Medical necessity - PAE eligibility criteria for the CV and TS rates will be handled by the LTC PAE unit.
- Eligibility criteria for CV reimbursement will be based on coverage criteria for PDN.
  - ventilator-dependent at least 12 hrs/day with an invasive patient end of the circuit
- Eligibility criteria for TS approved only for persons with a functioning tracheostomy who require suctioning through the tracheostomy, at a minimum, multiple times per eight-hour shift.
  - Suctioning of the nasal or oral cavity does not qualify

# Enhanced NF Rates (cont.)

- An MCO may authorize, based on medical necessity criteria, short-term payment at the TS rate for a person who has just been weaned from the ventilator, but who still requires short-term intensive respiratory intervention.
- Medical necessity criteria and authorization of the TS rate for such short-term purposes will be managed by VSHP.
- Authorization of the TS rate only for this short-term post-weaning intensive respiratory intervention shall be made only to NFs that meet standards of care for the delivery of ventilator services.

# Enhanced NF Rates (cont.)

A facility that provides ventilator services shall meet or exceed the the following minimum standards:

- **A licensed respiratory care practitioner, as defined by Tennessee Code Annotated Section 63-27-102(7), shall be on site 24 hours per day, seven days per week to provide:**
  - **ventilator care**
  - **administration of medical gases**
  - **administration of aerosol medications**
  - **diagnostic testing and monitoring of life support systems**
- **The facility shall ensure that an appropriate individualized plan of care is prepared for each patient requiring ventilator services, with input and participation from a pulmonologist or a physician with experience in ventilator care.**
- **The facility shall establish admissions criteria to ensure the medical stability of ventilator-dependent patients prior to transfer from an acute care setting.**



# Critical Incident Reporting

**Critical incidents shall include – but not be limited to – the following incidents when they occur in a home and community-based long-term care services delivery setting:**

- Unexpected death of a CHOICES member
- Suspected physical or mental abuse of a CHOICES member
- Theft or 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.

**Critical Incidents should be reported to VSHP Care Coordination immediately upon discovery.**

# CHOICES Toll-Free Numbers – For Care Coordination

**1-888-747-8955**



# Nurseline

- VSHP members may speak to a Registered Nurse (RN) anytime - 24 hours a day, 7 days a week - with 24/7 Nurseline:

**1-800-262-2873**



# Billing



The image shows a pair of glasses resting on a "HEALTH INSURANCE CLAIM FORM". The form is filled with various fields and checkboxes, including sections for patient information, insurance details, and employment status. The text on the form is partially obscured by the glasses and is somewhat blurry.

**HEALTH INSURANCE CLAIM FORM**  
(FOR PROGRAM)

1. MEDICARE  MEDICAID  CHAMPUS  CHAMPVA  (VA File #)  GROUP HEALTH PLAN (SSN or ID)  FECA BLK LUNG (SSN)  OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) \_\_\_\_\_

3. PATIENT'S BIRTH DATE MM / DO / YY \_\_\_\_\_ SEX M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) \_\_\_\_\_

5. INSURED'S I.D. NUMBER \_\_\_\_\_

6. PATIENT STATUS: Self  Spouse  Child  Other

7. EMPLOYMENT? (CURRENT OR PREVIOUS): Employed  Full-Time Student  Part-Time Student  Other

8. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES  NO  b. AUTO ACCIDENT? YES  NO  c. OTHER ACCIDENT? YES  NO

9. RESERVED FOR LOCAL USE

10. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES  NO

11. INSURED'S POLICY NUMBER OR FECA NUMBER \_\_\_\_\_

12. INSURED'S DATE OF BIRTH MM / YY \_\_\_\_\_

13. INSURED'S NAME OR SCHOOL NAME \_\_\_\_\_

14. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES  NO

15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Type name of insured person or authorized person) \_\_\_\_\_

16. DATE OF SIGNATURE \_\_\_\_\_

17. PHYSICIAN'S SIGNATURE (Type name of physician) \_\_\_\_\_

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100. DATE OF SIGNATURE \_\_\_\_\_

# Submitting Clean Claims

- The Electronic Visit Verification (EVV) System will create an electronic claims submission file which may be submitted to VSHP for claims processing.
- 90% of clean electronic claims will be processed and paid by VSHP within 14 calendar days of receipt. 99.5% will be paid within 21 calendar days.
- Claims submitted must include the Provider's Tax ID number, the National Provider Identifier and the required data elements.
- Paper Claims may be submitted as UB-04 claims
- Contracted and non-contracted providers must submit all claims for medical services within 120 days of the date of service.
- The Provider Manual has additional tips for completing claims under Section V: Billing and Reimbursement. Accessible at [www.bcbst.com](http://www.bcbst.com).

# Claims Submission

## **EVV**

- Adult Day Care
- Attendant Care
- Companion Care
- Home Delivered Meals
- Homemaker Services
- In-Home Respite
- Personal Care

## **Electronic Clearing House**

- Assisted Care Living Facilities
- Assistive Technology
- Critical Adult Care Homes
- Minor Home Modifications
- Nursing Facilities
- Personal Emergency Response Systems (PERS)
- Pest Control

## **Paper Claims**

Claims Service Center

P.O. Box 182277

Chattanooga, TN 37422-7277

# Electronic Visit Verification (EVV)

- EVV System Required for CHOICES HCBS only
  - Tracks the provision of certain HCBS
  - Facilitates timely payment
  - Increases ability to detect and resolve problems
    - Service gaps
    - Delays in service delivery
- Log in/Log out by phone
- In-depth training for HCBS providers upon request

# NF Billing

Revenue Code	Description	Comment	Rate
191	Subacute Care Level 1	Level 1 ICF - Applicable for Short and Long Term Stays	
192	Subacute Care Level 2	Level 2 SNF - Applicable for Short and Long Term Stays	
192	Subacute Care Level 2 - Enhanced	Chronic Ventilator Care - Billed with Procedure Code 94004	\$600
192	Subacute Care Level 2 - Enhanced	Vent Weaning - Billed with Procedure Code 94004 and Mod 22	\$750
192	Subacute Care Level 2 - Enhanced	Tracheal Suctioning - Billed with Procedure Code 94004 and Mod 52	\$400
185*	LOA	Nursing Home - Hospital bed hold for ICF only	
183*	LOA	Therapeutic Leave - Overnight home visits for ICF only	
189*	LOA	Other - Non-covered day - ICF, SNF, and ICF-MR	
224	Date of Discharge if Patient's discharge status is deceased.		
224	Date of Discharge if Patient's discharge status is deceased. Enhanced - Chronic Ventilator Care	Chronic Ventilator Care - Billed with Procedure Code 94004	\$600
224	Date of Discharge if Patient's discharge status is deceased. Enhanced - Vent Weaning	Vent Weaning - Billed with Procedure Code 94004 and Mod 22	\$750
224	Date of Discharge if Patient's discharge status is deceased. Enhanced - Tracheal Suctioning	Tracheal Suctioning - Billed with Procedure Code 94004 and Mod 52	\$400



# NF Billing (cont.)

- \*LOA for both hospital and therapeutic leave allows 10 paid days per fiscal year to use however the patient chooses. LOA may only be claimed by facilities with 85% occupancy or greater. (1200-13-1.06(4)(b))
- \*LOA for ICF-MR is 15 days per occurrence (per hospital stay) and 60 therapeutic leave days per year, not to be taken in greater than 2-week increments at a time. (1200-13-1.06 (31)(c )).

# Physician Visit Reporting

- **Physician Visits must be reported on claims**
  - **Occurrence Code 54**
  - **Date of Visit**
    - **FL 31-34**



# Contact Provider Network Services for:

- Electronic Enrollment Questions
- Status of Electronic Enrollment

**1-800-924-7141** or Email: [ecomm\\_sysconfig@bcbst.com](mailto:ecomm_sysconfig@bcbst.com)

Enrollment paperwork and user guides are available on [www.bcbst.com/providers/ecomm/getting\\_started/](http://www.bcbst.com/providers/ecomm/getting_started/)

# Contact eBusiness Solutions for:

- Technical Support
  - HyperTerminal Setup

(423) 535-5717 or Email: [ecomm\\_techsupport@bcbst.com](mailto:ecomm_techsupport@bcbst.com)

Additional instructions and information are available in the eBusiness User Guide located on the below web address.  
[www.bcbst.com/providers/ecomm/](http://www.bcbst.com/providers/ecomm/)

# Electronic Billing (cont.)

List of ANSI-Approved Software Vendors:

- [www.bcbst.com/providers/ecommm/ANSI\\_vendors/Vendors\\_list.asp](http://www.bcbst.com/providers/ecommm/ANSI_vendors/Vendors_list.asp)
- Payer Code 00890

# If you don't contract with VSHP...

- Nursing Facilities are NOT obligated to contract with VSHP ***BUT.....***
- Existing Medicaid fee-for-service system will no longer exist once CHOICES is implemented
- Non-contracted facilities will be reimbursed by VSHP for services provided to existing Medicaid/LTC members – but at a lower payment rate than if contracted with VSHP
  - **80% of the lowest rate paid by VSHP to participating network providers for the same service (as set forth in TennCare Rule)**
- VSHP will seek to admit all new residents to contracted facilities

# Provider Roles & Responsibilities

- Agree that VSHP may monitor quality of services delivered under the provider agreement.
- Comply with corrective action plans if needed to improve quality of care.
- Submit reports and clinical information timely as needed.
- Provide name and address of official payee.
- Make full disclosure of the method and amount of compensation to be received from VSHP.
- Be responsible for ensuring any applicable authorization requirements are met and verifying the person is eligible for TennCare on the date of service.
- Provide for prompt submission of information needed to make payment (usually within 120 calendar days from the date of rendering a covered service).
- Accept payment or appropriate denial made by VSHP, and not solicit or accept any surety or guarantee of payment from the enrollee in excess of the amount of applicable TennCare cost sharing responsibilities.

# Roles and Responsibilities Continued

- Identify third party liability coverage, including Medicare and long-term care insurance as applicable, and bill them first.
- Report suspected fraud or abuse of TennCare.
- Report suspected abuse, neglect and exploitation of adults, and suspected brutality, abuse or neglect of children.
- Report any known significant changes in the member's condition or care, hospitalizations, or recommendations for additional services.
- Conduct background checks in accordance with state law and TennCare policy.
- Recognize and abide by all state and federal laws, regulations and guidelines applicable.
- Safeguard information about enrollees according to state and federal laws and regulations.
- Display notices of the enrollee's right to appeal adverse action affective services in public areas of your facility, as applicable.



# Approval of Subcontracts

- VSHP is required by TennCare to assure that contracted providers do not enter into subcontracts for any of the services covered under their provider agreement without the prior written approval of VSHP.
  - Pertains only to the delivery of services under the provider agreement for which Medicaid payment will be made (does not include contracts such as vending machine agreements or other supportive services)

# Out of Network Providers

TennCare Rules specifically exclude coverage for non-emergency services that are ordered or furnished by an out-of-network provider.

If the physician currently serving residents in the facility is not a contracted provider, s/he may be able to enroll as a contracted provider.

Providers may request VSHP applications and contracts by calling 1-800-924-7141.

# Credentialing

- Part of the Contracting process
  - ALL providers must be credentialed in order to participate in VSHP's network
  - Process by which VSHP verifies providers meet all applicable state and federal provider qualifications
  - Must be conducted in accordance with National Committee for Quality Assurance (NCQA) guidelines
- Specifics for Nursing Facility Providers
  - Providers who meet CMS conditions of participation will be included in the VSHP network
  - Verification of existing Medicaid provider information
  - VSHP will work with NF to streamline the process as much as possible

# Provider Complaints

## 1. Inquiry/Consideration

Providers should contact VSHP if there is a dispute concerning claims, authorization or other issues within the provider and VSHP's control.

## 2. Appeal

If not satisfied, a written appeal may be submitted within 30 days after receiving the other party's response to its inquiry/reconsideration.

## 3. Mediation

A party may request mediation by submitting a written request within 30 days of receipt of the other party's appeal response.

## 4. Binding Arbitration

Either party may make a written demand for binding arbitration within 30 days after it receives a response to its appeal or the conclusion of the mediation of that dispute.

**Please refer to the Provider Administration Manual for the appropriate forms at [www.bcbst.com](http://www.bcbst.com)**

# For More Information About the DHS Application

- [www.tn.gov/humanserv/forms/hs-0169.pdf](http://www.tn.gov/humanserv/forms/hs-0169.pdf)
  - DHS Application (12 pages)
  - Instructions
- [www.tn.gov/humanserv/adfam/afs\\_med.html](http://www.tn.gov/humanserv/adfam/afs_med.html)
  - Information about Medicaid/TennCare
  - Online DHS Application

# For More Information About the PAE

- [www.tn.gov/tenncare/forms/memotopaeform.pdf](http://www.tn.gov/tenncare/forms/memotopaeform.pdf)
  - PAE Form
  - Memo
  - Checklist

# For More Information About the PASRR

- [www.tn.gov/tenncare/forms/pasrrmemo.pdf](http://www.tn.gov/tenncare/forms/pasrrmemo.pdf)
  - Pre-Admission Screening and Resident Review (PASRR) Form
  - Instructions
  - Workflow
  - Memo
  - FAQs

# Provider Relations Contacts

## East Grand Region

**Buffy Bass-Douglas**

Buffy\_Bass-Douglas@bcbst.com

(423) 535-3856

## Middle Grand Region

**Nathan Key**

Nathan\_Key@bcbst.com

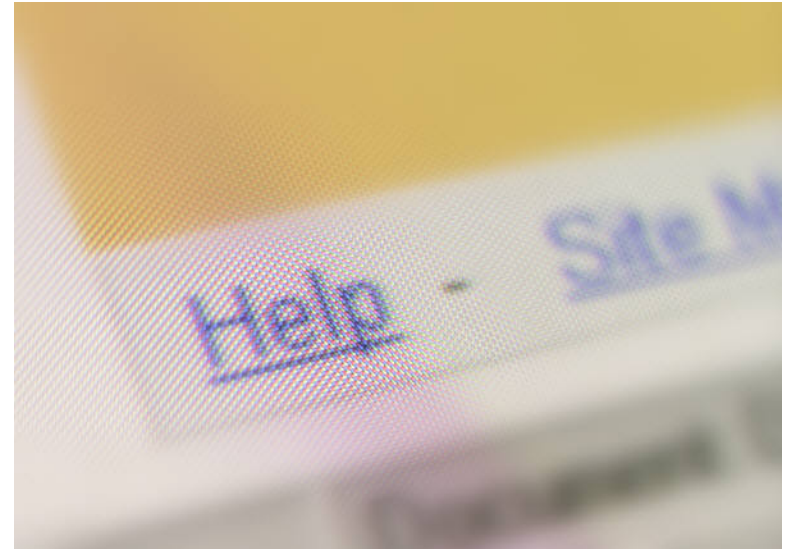
(615) 760-8707

## West Grand Region

**Sheldon House**

Sheldon\_House@bcbst.com

(901) 544-2170



**Provider Service Line**

**1-866-502-0056**

**Provider Manuals**

**[www.bcbst.com](http://www.bcbst.com)**