Weekly CHOICES News Alert

Volunteer State Health Plan

May 20, 2011

Important Numbers

Provider Hotline for Nursing Facilities

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

Care Coordination Phone Number

For questions concerning authorizations, care coordination, plans of care or items of that nature, please contact 1-888-747-8955.

You may also send your authorization questions to the providerauthissues_gm@bcbst.com mailbox.

PLEASE NOTE: Beginning June 1, 2011, the new hours of operation for Care Coordination will be 7 a.m. to 5 p.m. CT

BlueCare/TennCare*Select Customer Service*

BlueCare Provider Service:	1-800-468-9736
TennCare*Select* Provider Service:	1-800-276-1978
Automated Eligibility Line:	1-800-543-8607

CHOICES Network Representatives

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

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

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

Authorizations

Enhanced Rates for Nursing Facilities

To obtain authorization for enhanced rates for Nursing Facility Services, please contact Care Coordination.

For level 1 and level 2 services being provided that do not involve enhanced services, the PAE serves as the authorization.

Assistive Technology Authorizations

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

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

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

Pre-Admission Evaluations (PAEs) and Eligibility

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

Anytime a patient has a change in level of care, a new PAE is required. PAEs should be completed by the nursing home, doctor or hospital on a person and sent to the TennCare Long Term Care office.

If you need a copy of the PAE form for your records, please contact the Care Coordination Support Center and one will be sent to you.

FAQs

When should I call Care Coordination (CC)?
You should call CC at 1-888-747-8955 any time a change in status affects your claims payment.

What if another provider has called and notified CC of a member change?
If the status change could affect you and your claims payments, you should call CC, regardless if you think someone else has already called.

Should I receive a fax confirmation of my authorization?
Yes. If you do not, please call 1-888-747-8955 or contact your Provider Relations Representative.

Should I still be emailing providerauthissues_gm@bcbst.com for authorization issues?
Yes. However, at this time, the response may take longer than 5 days.

How do I get a copy of the member's insurance card?
Request a copy from the member.

If I don't have a copy of the card, how can I find out if the member is eligible and who is their MCO?
You may use http://www.tennesseeanytime.org/tncr/ to find out if the member is eligible for services and who is their MCO.

Is there a fee to use Tennessee Anytime?
Yes. There is an annual fee of $75.

Why must HCBS be made up within the same week of the missed visit?
Each member has a Plan of Care. Providers should follow this plan of care; therefore, services for that member should be provided as outlined – the same week a visit is missed.

Can we make up visits later the same day as the missed visit?
Yes. Please contact Care Coordination Service Center to update the authorization.

What if the member wants a missed visit to be made up on Saturday?
Please CALL Care Coordination Service Center (1-888-747-8955)

CHOICES Claims & Billing

Member Eligibility

VSHP 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 Bureau of TennCare's online services at http://www.state.tn.us/tenncare/pro-verifyeligi.html or by calling1-800-852-2683.

Providers may also call BlueCare at 1-800-468-9736 or TennCare*Select* at 1-800-276-1978 to verify eligibility. The lines are available Monday-Friday (except between 7p.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.

Remember, benefits are based on the member's eligibility when services are rendered. Benefits and eligibility are determined by the State Bureau of TennCare and are subject to change.

Minor Home Modification New Process

As promised the Minor Home Modification process has been streamlined to work better for the member, you and the CHOICES staff.

Effective immediately:

- Home modifications under $1,000 do not require 3 bids
- The winning bid and the cost **IS NOT** shared with the non-winning contractors. This is not new, but has been an ongoing question.

Please contact Care Coordination for a copy of the new BidderTool.

Timely Filing Extension

Due to unresolved authorization issues, the timely filing limitation for CHOICES claims has been extended through May 31, 2011. Please remember, if you have dates of service that **have not been previously submitted**, those claims should be submitted as quickly as possible to avoid any delays in payment. If you have any questions regarding claims submission, please contact your Network Representative.

CHOICES Billing Guidelines

When billing for services for CHOICES members, all BlueCare and TennCare*Select* billing guidelines apply. In addition, as a CHOICES provider, you must also follow the CHOICES specific billing guidelines.

For complete information regarding billing guidelines, please reference your VSHP Provider Administration

Manual at www.bcbst.com/providers/manuals

Claims Adjustments

If you have submitted a claim for adjustment, please allow two (2) to three (3) weeks for the adjustment to reflect on your Remittance Advice.

Determining a VSHP Member

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

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

CHOICES Eligibility and Liability Verifications

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

- If you disagree with the member's liability, you will need to submit a copy of the member's 2350 form. If you do not have a copy of this form, you will need to contact the Department of Human Services (DHS).
- If a member calls in disagreeing with the PLA, he/she will be instructed to have his/her provider contact us.
- If you state a member is CHOICES eligible or the member has a different level of care, you will need to fax the PAE to the attention of the Customer Service Representative you speak with.
- If a member changes from Level 1 to Level 2, you are required to add the MOPD in TPAES for the date the 1B began. If the member changes from Level 2 to Level 1, the same information is required.

Remittance Advice

Remember: To reconcile your books, Remittance Advices should be worked upon receipt. You may also access Remittance Advices via BlueAccess.

BlueAccess

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

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

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

Issue Reporting and Resolution

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

EVV

EVV Training

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

EVV Exceptions and Missed/Late Visits

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

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

Other Important Reminders

Hospice and CHOICES.

Hospice care is not a long-term care service under CHOICES. However, when a member enrolled in CHOICES chooses to receive hospice services certain programmatic changes occur.

NOTE: A CHOICES member does NOT lose TENNCARE eligibility because he chooses to receive hospice care either in his home or in a Nursing Facility (NF).

If a CHOICES member (CHOICES Group 1) is living in an NF at the time he opts to receive hospice care for his terminal illness, he will be disenrolled from the CHOICES program. However, he remains enrolled in the TennCare program for all covered services. As described above, his room and board at the NF becomes a part of the hospice benefit and it is no longer paid directly to the NF by his MCO. The enrollee will continue to have a patient liability for which he is responsible. See TennCare Policy Statement PAY 07-001 (Hospice and Patient Liability).

An individual enrolled in CHOICES Group 2 (HCBS) may elect hospice and continue to receive HCBS. However, the MCO is responsible in the needs assessment and care planning process for ensuring that services available under the hospice benefit are not supplanted by services provided through CHOICES. If a service that a member needs can be provided through the hospice benefit, it must be provided through either Medicare or TennCare.

If a CHOICES Group 2 member receiving hospice services in his home later decides to enter a NF, the process described above for a CHOICES Group 1 member will apply. That is, the member will be disenrolled from CHOICES, but NOT from TennCare, as the NF room and board is part of this hospice benefit. A patient liability amount will be calculated for the individual by DHS for which he will be responsible for making payment to the NF.

For complete information, please go to http://www.tn.gov/tenncare/forms/ben07001.pdf

Member Changes

If you have a member admitted to the hospital, you must contact Care Coordination as soon as possible. A delay of notification will result in authorization and claims errors. Also, anytime a member has a change in demographics (i.e. address, phone, etc.) this information must be reported to DHS in order for the system to be updated correctly. The member and/or the member's representative must report this information.

PERS and Temporary Hospital or Nursing Facility Stays

If a member is admitted for a temporary hospital or nursing facility stay, the PERS unit should remain in the member's home and monitoring should be temporarily suspended. VSHP should not be billed for charges occurred while the member is out of the home.

If the member is permanently removed from the home, the equipment can be retrieved at this time.

It is crucial that VSHP be notified when members are admitted to the hospital.

Reminder: TennCare Member Appeal Poster Must be Displayed

The Bureau of TennCare requires the Member Appeal Poster be displayed in a visible location within provider offices in the event the member has a grievance with the managed care organization or the provider. The poster is available on the company website at http://www.bcbst.com/providers/forms/ and on the Bureau of TennCare's website at <http://www.tn.gov/tenncare/forms/medicalappeal.pdf>. Please be sure to display this poster in your office for BlueCare and TennCare*Select* members.

Change of Ownership and Change in Demographics

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

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

Town Halls and Webinars

Monthly Webinars

Volunteer State Health Plan (VSHP) has scheduled a CHOICES Town Hall Webinar to assist with various provider issues related to the CHOICES program. During each meeting, we will discuss in detail several issues related to CHOICES.

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

Webinar Log in Information:
https://www.teleconference.att.com/servlet/AWMlogin?process=8&brand=att&AT=LO&ST=SUCCESS
Meeting Number: 734-414-0270
Meeting Code: 113365
May 26, 2011
Time: 10 a.m. to 1 p.m. ET

Quarterly Town Halls

Volunteer State Health Plan (VSHP), in conjunction with UnitedHealthcare Community Plan (AmeriChoice), has scheduled Town Hall Meetings for June, 2011 to assist with various provider issues related to the CHOICES program.

There will be two (2) meetings in the West Grand Region, three (3) in both the Middle Grand Region and the East Grand Region.

Because space is limited, all providers are limited to three (3) attendees. RSVPs are required. Once the spaces are filled, no more RSVPs will be accepted.

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

West Grand Region

Memphis
St. Francis Hospital
Longinotti Auditorium
5959 Park Avenue
Memphis, TN 38119
June 21, 2011
Meeting Time: 9 a.m. to noon CT

Humboldt
Humboldt General Hospital
Conference Room #1, Humboldt Conference Center
3525 Chere Carol Rd
Humboldt, TN 38343
June 22, 2011
Meeting Time: 9 a.m. to noon CT

Middle Grand Region

At this time, the Middle Town Halls are still being scheduled.

East Grand Region

Knoxville
Hilton Garden Inn Knoxville West
Garden Room
216 Peregrine Way
Knoxville, TN 37922
June 7, 2011
Meeting Time: 9 a.m. to noon ET

Bristol
The Bristol Train Station
101 Martin Luther King Jr. Blvd
Bristol VA 24201
June 15, 2011
Meeting Time: 9 a.m. to noon ET

Chattanooga
BlueCross BlueShield of Tennessee
Community Room
1 Cameron Hill Circle
Chattanooga, TN 37402
June 28, 2011
Meeting Time: 9 a.m. to noon ET