Wellpoint

Medicaid

Provider Quick Reference Guide for TennCare CHOICES

Long-Term Services and Supports:

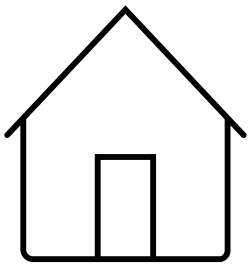
866-840-4991 | https://provider.wellpoint.com/TN/

This guide includes information on the following topics:

- Important phone numbers
- Benefits available under the CHOICES program
- Claim submission guidelines
- Care coordination
- Person-Centered Support Plan
- Registration with the Division of TennCare

CHOICES

CHOICES is a managed long-term services and supports (MLTSS) program that offers services to help members live in their own home or in the community. These services are called home and community based services (HCBS). These services can be provided in the home, on the job, or in the community to assist with activities of daily living and to allow people to work and be actively involved in their local community.



Who is it for?

- Adults (age 21 and older) with a physical disability
- Seniors (age 65 and older)

What does it offer?

- Support for families caring for a person with a disability or who is elderly
- Support to help people with disabilities or the elderly with independent living goals
- Help for people with complex needs who need more support to live in the community or who need residential and other day services to help them achieve their community living goals
- 24-hour support for some members who qualify for companion care through consumer direction

CHOICES services and supports

Service and benefit limit	Group 1	Group 2 (Full Medicaid eligibility)	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short term only (up to 90 days)
Community-based residential alternatives (CBRA): • Assisted care living facility • Community Living Supports • Community Living Supports — family model • Critical adult care home • Companion care		X	Specified CBRA services and levels of reimbursement only (See below)[1]
Personal care visits (up to two visits per day at intervals of no less than four hours between visits)		X	X
Attendant care • Up to 1,080 hours per calendar year • Up to 1,400 hours per calendar year for those who require assistance with household chores or errands in addition to hands-on assistance with self-care tasks		X	X
Meals delivered to the home (up to one meal per day)		X	X
Personal emergency response systems (PERS) (One unit installation, one unit per month for 12 months per year)		X	X
Adult day care (up to 2,080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
Inpatient respite care (up to nine days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Minor home modifications (up to $6,000 per project, $10,000 per calendar year and $20,000 per lifetime)		X	X
Pest control (up to nine units per calendar year)		X	X
Enabling technology (For CHOICES members, Enabling Technology is limited to $5,000 per year and is available through March 31, 2024.)		X	X

1 CBRAs for which Group 3 members are eligible include only: assisted care living facility services, Community Living Supports 1 (CLS1) and Community Living Supports — Family Model 1 (CLS-FM1).

Quality monitoring

Wellpoint is responsible for ensuring that each Community Living Supports (CLS) provider within the CHOICES network maintains compliance related to quality of care and service provision. This is accomplished through oversight and monitoring by the Wellpoint Provider Relations and Quality teams.

Reportable event reporting and management

Reportable event management (REM) is one important component of an overall approach for ensuring the health, safety, individual freedom, and quality of life of people participating in home- and community-based services (HCBS) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services:

- A reportable event is an event that is classified as Tier 1 or Tier 2, or additional reportable events, as defined by the Division of TennCare, that the contracted provider, Wellpoint, or FEA staff will be responsible for reporting to Wellpoint and/or the Department of Intellectual & Developmental Disabilities (DIDD), as specified by the Division of TennCare.
- Non-reportable events are not reportable to DIDD. The MCO providers are expected to document, perform data collection and trend analysis, and address these events internally as part of strategic quality improvement processes that lead to improved outcomes.

Please email reportable event documentation and questions to Employment and Community First CHOICES Reportable Events Management via email at TN-REM@amerigroup.com or fax to **844-759-5952** (fax only if email is not available).

- Adult Protective Services (APS):
  - Phone: **888-277-8366**
  - Fax: **866-294-3961**
- Child Protective Services (CPS):
  - Phone: **877-237-0004**
- DIDD investigations hotline — 24 hours a day, 7 days a week — for **Tier 1 reportable events only:**
  - **888-633-1313** (Statewide)

Care Coordinators

- Conduct person-centered needs assessment to develop the Person-Centered Support Plan (PCSP) and update the plan to accurately reflect any changes in the member's circumstance and/or impact on the member's needs.
- Provide information about participating providers.
- Support the person in identifying and meeting goals for a more independent and community-integrated lifestyle.
- Act as a resource to identify paid and unpaid supports available to the person.
- Provide coordination of services to promote continuity of care, including discharge planning following an inpatient stay.

Person-Centered Support Plan (PCSP)

- The PCSP is developed through the completed person-centered planning process and assessments.
- It is a comprehensive plan that includes individually identified employment, community living, and health and wellness goals.
- Providers serving CHOICES members are responsible for using the PCSP to ensure they are providing services in accordance with the PCSP and training staff to meet the individual needs of the person supported.
- The PCSP is ***not*** used to determine funding level, but is a description of the person's support needs and individually identified goals that should evolve to meet and respond to changing support needs in a timely manner.
- Individual PCSPs must be reviewed, signed, and returned by the provider before beginning services.
- A copy of the PCSP will be provided to the individual, the individual's representative, and the selected CHOICES providers, including the member's PCP.
- The PCSP is the plan of care.

Authorization/notification instructions

Authorization is required for all CHOICES services (excluding level 1 nursing facility services). Wellpoint will provide an authorization in accordance with the individual's PCSP. To request a non-EVV service authorization, please send an email to ltcprovreq@amerigroup.com and include the following information:

- Provider name/Wellpoint provider ID
- Individual name/Wellpoint subscriber ID
- Service, dates of service, and unit amount requested
- Individual schedule (for services monitored through electronic visit verification [EVV])
- Authorization request for EVV services must be submitted in the EVV system

Billing and claims submission

To initiate billing for the approved reimbursement, a claim must be submitted based on the specified CHOICES service type. Claims will be submitted through the EVV system or through the Availity Essentials claims system.

For EVV:

- The Wellpoint EVV vendor is CareBridge.

For Availity Essentials submission:

- Submit a ***CMS-1450 (UB04)*** claim form via Availity Essentials.
- Bill using a federally assigned NPI and tax identification number.

CareBridge — Electronic visit verification (EVV) system

The EVV system is an automated system that Wellpoint uses to monitor an individual's receipt of home- and community-based services (HCBS). For each period of service delivery, providers are required to check in at the beginning and check out at the end. This will provide the required confirmation that the individual has received the authorized HCBS services in accordance with their PCSP.

To use the EVV system, providers check in at the individual's home promptly upon arrival using a Global Positioning System (GPS) tablet device, smartphone app, or telephone device. The provider's employee may download the Wellpoint EVV application to their own Android or Apple smartphone at no charge and may use it for checking in and out of a visit if the individual's tablet is not available. This confirms the identity of the individual provider/staff worker, the arrival time, and location. At the end of the shift or assignment (and prior to leaving the individual's home), the provider/staff worker will check out using the tablet device, logging the departure time, and completing a brief survey. If a provider/staff worker fails to check in at the appropriate time, the EVV system will alert Wellpoint to a late/missed visit and steps will be taken to ensure the individual receives the appropriate care at the appropriate time. At a minimum, providers shall have at least one full-time staff person devoted to EVV system monitoring and two staff members fully trained and knowledgeable of the EVV system and its functionality. Use of this system is compulsory by providers administering HCBS services.

CareBridge — Electronic visit verification (EVV) system (cont.)

Wellpoint requires that all contracted providers use the EVV system for applicable services. Caregivers have the first line of sight into any tablet device issues, so please be sure to notify the EVV team of any issues with the tablet or other methods of check in/out. Notify Wellpoint immediately utilizing the Get Support function in the EVV system or by sending an email to the provider request mailbox at ltcprovreq@amerigroup.com if the tablet device is not available, unable to be turned on, not receiving a signal, or broken and/or the caregiver is unable to use the mobile application for check in/out. At least one staff person with the contracted provider should monitor caregiver activity to ensure caregivers are in the person's home providing services at the scheduled time agreed upon when the referral was accepted, including after-hours and weekends, if the person is scheduled to receive care during those times.

It is imperative that providers comply with these standards to ensure that individuals are receiving services in a timely manner. To maintain acceptable compliance scores, it is required that 90% (or more) of scheduled services submitted for payment have GPS coordinates attached. Providers are required to submit specific late and missed appointment information to Wellpoint for monthly reporting to the Division of TennCare. Providers that have not met the minimum performance requirements are subject to corrective actions up to individual moratoriums, possible liquidated damages, or termination from the provider network.

Our service partners

CareBridge	**855-329-2116**
Tennessee Carriers (nonemergency transportation)	**866-680-0633**
Availity Essentials	**800-282-4548**
Division of TennCare	**800-342-3145**

Local Provider Relations

We also offer local Provider Relations representatives who help providers with ongoing education, contract and fee issues, procedural issues, and more. Your office has a designated representative you can reach at **615-316-2400, ext. 22160**.

Email is the quickest and most direct way to receive important information from Wellpoint. To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right via our online form (**https://bit.ly/2XxYAEg**).

24-hour Nurse HelpLine • 866-864-2544 (Spanish: 866-864-2545)

The 24-hour Nurse HelpLine is a telephonic, 24-hour triage service Wellpoint members can call to speak with a registered nurse who can help them:

- Find doctors whether after hours or on weekends.
- Schedule appointments.
- Get to urgent care centers or walk-in clinics.
- Speak directly with a doctor or a member of the doctor's staff to talk about their healthcare needs.

Our Member Services line at **800-600-4441** offers no cost translation services for 170 languages and the use of a TDD line for members with difficulty hearing.

We encourage providers to tell their patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Timely filing

Timely filing is within 120 days from the date of service. Timely filing is within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation, or in cases where a member has retroactive eligibility.

Electronic Data Interchange (EDI)

Availity Essentials is our exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Availity Essentials EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Or use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity Essentials EDI Gateway)

To become an EDI Trading Partner, visit **https://www.availity.com**. Login if already an Availity Essentials user, choose My providers > Transaction Enrollment or choose **Register** if new to Availity Essentials.

Interactive Care Reviewer (ICR) tool via Availity Essentials:

- Your practice can initiate online precertification requests for TennCare members more efficiently and conveniently with our ICR tool, available via Availity Essentials.
- The ICR offers a streamlined process to request inpatient and outpatient procedures through the Availity Portal.
- For questions on accessing our tool via Availity, call Availity Essentials Client Services at **800-AVAILITY**. Availity Essentials Client Services is available Monday to Friday from 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions.

Electronic claim payment reconsideration:

- Providers have the ability to submit claim reconsideration requests via Availity Essentials with more robust functionality, including:
  - Filing a claim payment reconsideration.
  - Sending supporting documentation.
  - Checking the status of your claim payment reconsideration.
  - Viewing your claim payment reconsideration history.

Availity Essentials functionality includes:

- Acknowledgement of submission at the time of submission.
- Email notification when a reconsideration has been finalized by Wellpoint.
- A worklist of open submissions to check a reconsideration status.
- Paper claims.

Electronic funds transfer (EFT) and *Electronic Remittance Advice* (*ERA*) registration

Electronic Remittance Advice (835):

The 835 eliminates the need for paper remittance reconciliation. Use Availity Essentials to register and manage *ERA* account changes with these three easy steps:

1. Log in to **Availity**.
2. Select **My Providers**.
3. Select **Enrollment Center** and select **Transaction Enrollment**.

Note: If you use a clearinghouse or vendor, please work with them on *ERA* registration and receiving your *ERA*'s.

Electronic Funds Transfer (EFT):

Electronic claims payment through electronic funds transfer (EFT) is a secure and fastest way to receive payment reducing administrative processes. EFT deposit is assigned a trace number that is matched to the 835 *ERA* for simple payment reconciliation.

Effective November 1, 2021, use **EnrollSafe** to register and manage EFT account changes.

Claims adjudication and dispute process

- Wellpoint produces and mails *EOPs* on a semiweekly basis, which delineates for the provider the status of each claim that has been adjudicated during the previous claim cycle.
- Providers are responsible for reviewing their *EOPs* to identify claims for which they disagree with the adjudication determination (denied, underpaid, overpaid, etc.).
- Providers must follow the provider payment dispute process for all denied claims with which they disagree. The Wellpoint dispute process includes an initial claim payment reconsideration. If the provider disagrees with the reconsideration decision, they may submit a claim payment appeal.

Payment disputes must be received by Wellpoint within 365 days of the date of the *EOP*. In order to submit a claim payment reconsideration and/or claim payment appeal, providers should use Availity Essentials and access the Claim Dispute Tool. Providers may also contact Provider Services at **800-454-3730**.

- Providers can check the status of disputes via Availity Essentials.
- Dispute decision letters will also be accessible via Availity Essentials.

Division of TennCare provider registration

The Division of TennCare collects *Disclosure of Ownership* information for new and existing providers, both provider persons and provider entities. Both new and existing Medicaid providers need to register their information on the *TennCare Provider Registration* site at **tn.gov/tenncare/providers/provider-registration.html**.

If you have questions or need assistance, please call **800-852-2683** Monday to Friday, 8 a.m. to 4:30 p.m. CT.

Medical appeals

Members and their representative(s), including the member's provider, have 60 calendar days from the date on an adverse action in which to file an appeal. The member may use the *TennCare Medical Appeal* form, but it is not required. The member or member's representative can file an appeal of an adverse action with the TennCare Solutions Unit (TSU):

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Fax: **888-345-5575**
Phone: **800-878-3192**
TTY/TDD: **800-772-7647**
Español: **800-254-7568**

TSU forwards any valid factual disputes to Wellpoint for reconsideration. TSU faxes an *On Request Report* to Wellpoint requesting reconsideration of the member's appeal.

Claim overpayments

For provider-identified claim overpayments, providers must follow the guidelines laid out in their Wellpoint contract and complete the *Overpayment Refund Notification Form*. Providers should mail this information to Wellpoint:

Wellpoint
P.O. Box 933657
Atlanta, GA 31193-3657

For claim overpayments identified by Wellpoint, providers should follow the directions on the overpayment request letter they receive from our Cost Containment Unit.

https://provider.wellpoint.com/TN/

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