BlueCare Tennessee | BlueCare℠ TennCare*Select* CoverKids

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BlueCare Tennessee Provider Administration Manual

Important Changes: Effective July 1, 2026

The following table highlights important upcoming changes to guidelines and policies in this quarter's BlueCare Tennessee Provider Administration Manual.

Note: All changes reflected in the Manual are not listed in this table.

Section # and Title	Affected Page(s)	Modification
I. Introduction	14	**B. Description of Health Plans and Health Plan Sub Programs** 1. BlueCare Tennessee operates two TennCare Program Health Plans: • Contact Grid under the Grand Regions Maps – Removed contact details for Prior Authorization for DME and Home Health Services from grid.
	17 20	**C. General Information** 1. Nondiscrimination Requirements – Replace "equity" with "equal outcomes" in 1st paragraph. 6. Protected Health Information-allowable disclosure under HIPAA • Added "Interoperability Standards and the HITECH Act" title and language at the end of this subsection. This language was relocated from the Provider Networks section of this manual.
	26 27 27	**E. Important Contact Information** • Within the grid ○ Provider Network & Contracting/Provider Relations, under phone column – Changed Option 2 to Option 1 ○ Home Health/PDN Missed Visit Reporting Line – Removed Phone # and added Availity in Contact Column ○ Removed "DME State; Home Health" from "Inpatient/Outpatient BH" title. Relocated" BlueCare" and "TennCare Select" titles along with their corresponding phone & fax, and description.
III. PCP Member Assignment	46	**C. Primary Care Provider (PCP) Changes** 1. PCP Change Initiated When: last bullet – Corrected hyperlink for www.bcbst.com.
IV. Benefits	50-51 54-55	**A. Covered Benefits** 17. Obesity Services – Added new subsection title and language with grid. 22 Home Health Care Services – Removed language from beginning of 3rd paragraph regarding prior authorization. Added clarity language as 3rd-5th paragraph for prior authorization.
	58 60 60	24. Durable Medical Equipment (DME) ○ Added language regarding DME network transition as of. 3/6/26 (1st paragraph). ○ Respiratory Care Supplies & Equipment Providers – Removed Title and related language below it and also contact details. ○ Updated language within 2nd Note.
V. Billing & Reimbursement	65 73	• 6th paragraph, updated hyperlink. **C. Timely Filing Guidelines** • 1st paragraph – Within 1st sentence removed language with effective

Section # and Title	Affected Page(s)	Modification
Billing & Reimbursement (Cont'd)		dates. And later in same paragraph, updated "From" date to "Through" date
		F. General Billing and Reimbursement Information
		22. Bioengineered Skin and Soft Tissue Substitutes
	94	• Added new reimbursement header and language.
		I. Specific CMS-1500 Claim Form Billing and Reimbursement Guidelines
		5. OB/GYN Services
	126	• Note regarding Lactation Services - Updated language
		J. Staff Supervision – Requirements for Delegated Services
	169-173	• Updated policy language almost in its entirety.
VIII. UM Program		**A. Program Overview**
	225	• Behavioral Health, Note: Updated language.
		D. Outpatient Services Requiring Prior Authorization
	228	• Removed 5th bullet/language for Sleep Studies
		F. Advanced Imaging Prior Authorization Requirements
	230	• Changed hyperlink in 2nd paragraph.
		G. DME, O&P, Medical Supply PA Requirements
	230	• Added 4th paragraph language regarding DME network transition as of. 3/6/26.
	232	• Respiratory Care Supplies & Equipment Providers – Updated title by removing "Equipment Providers" and removed relative language eff. 1/1/2020 (1st paragraph).
	232	• Incontinence Supplies – Removed language eff. 2/1/24 with details for vendor and contact details request incontinence supplies (1st paragraph and contact grid). Also, removed "HCD" from 2nd Note above the code grid.
		J. Home Health and Private Duty Nursing Prior Authorization Requirements
	233	• At beginning of section, removed bulleted language and Note. Added clarity language as 1st - 3rd paragraphs.
	235	• Private Duty Nursing (PDN) services – Removed 2nd paragraph language regard prior authorization requirement.
IX. OB Services	248-249	• Added acronym "(BCT)" after BlueCare Tennessee (1st paragraph), and replaced BlueCare Tennessee with BCT thereafter where applicable.
X. Population Health Management Program	Various	• Throughout section, updated acronyms/phrases: "Population Health" with "PH", "BlueCross Tennessee" with "BCT".
	250	• 1st paragraph – Removed "Tennessee" after BlueCare, relocated "I/DD MLTSS" after the phrase instead of in front of it, and added acronym "PH" acronym after Population Health.
		A. Components
		3. Helping individuals with complex health problems better manage their condition
	251	• Members with high-risk needs - Updated 4th bullet with phrase instead of acronym "DME".
	252	• Complex case management - Removed "(CM)" from Complex Case Management in 1st paragraph, and replaced "CM" for "Case Management" in 2nd paragraph.
		C. Evaluation of the Population Health Management Program
	254	• 1st paragraph– spelled out phrase for HEDIS acronym and added NCQA guideline for registered trademark language at the end of the page since this is where "HEDIS" is first used.

Section # and Title	Affected Page(s)	Modification
XI. Quality Improvement Program	Various 256 & 257 256-258 258-259 259-261	• Throughout this section, updated acronyms/phrases: BlueCross Tennessee with "BCT", "quality improvement" with "QI", and Population Health Quality Improvement Program with "PHQIP". • Added registered trademark reference at end of pages where HEDIS & CAHPS was first used. **A. Introduction** • Updated language and bulleted language, as needed. **B. Scope of Responsibility** • Updated language, and bulleted language, as needed. **C. Structure** • Updated language, and bulleted language, as needed.
XII. Provider Agreement	275 277 282 283 283 285-286 286 287 289	**A. Reconsideration (1st Level Appeal)** • 2. How to submit Reconsiderations – Removed language regarding out of state providers reconsiderations & link to the pdf. Removed "in state" and the Note at end regarding ER Reconsiderations with fax#. **B. Provider Dispute Resolution Process** • II. D. – Removed the language and text box regarding the replacement of the former Provider Dispute Form. Also, within the remaining textbox, removed language regarding the Provider Appeal Form and link, and updated process to "Appeals and Reconsideration" for clarity. **C. TennCare Provider Agreement Requirements** • #44 - Added "submit a written" to language • #48 - Removed "ISC/DDA Case Manager" from 1st sentence language. • #53 - Added language to last sentence. • #72 - Updated/added language to 2nd paragraph language. • #75 – Added/updated language • #84 – Added language to "a." • #103 – added "contracted" to 1st sentence
XIII. ASH	293	**B. Sterilization** • Guidelines: 10., Updated interpreter and recipients signature language and added teleconference/consent details.
XIV. Preventive Care	Various 295 295 297 298 300 300 300 303	• Throughout this section, updated phrases/acronyms: BlueCross Tennessee with "BCT", "Clinical Quality Improvement" with "CQI", "Primary Care Physician" with "PCP", "Vaccines for Children" with "VFC" • Added language for registered trademark reference at end of pages where HEDIS was first used. **A. Prevention and Wellness** • 3rd set of bullets, 4th bullet – Added phrase for HEDIS acronym. **B. Preventive Care Guidelines** • Primary Care Practitioner Responsibilities – 4th bullet, removed numbering from language. • BCT Responsibilities – Removed language in last paragraph. • TennCare Preventive Health Standard for Non-Pregnant Adults o Immunizations – Updated language and hyperlink. • Periodicity for Subsequent Visits o Added language under Laboratory. o Immunizations – Updated language and hyperlink, as applicable. **C. Preventive Care Services Billing Requirements** • VFC – removed "providers" and added "$10.25 per vaccine" and added "the Division of" before TennCare at end of last paragraph.

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XV. Behavioral Health Services	320 321 327 328-329 330	**F. Transcranial Magnetic Stimulation** • Updated last sentence of 2nd paragraph regarding qualifications for all TMS services. • Removed language from 5th paragraph regarding retro authorization requests submissions for services delivered from 1/10/18-6/30/18. **K. Access and Availability of Behavior Health Services** • Added new header and language for Medical and Behavioral Health, Emergency Care for Adult and Child Standard. **L. Behavioral Health Quality of Care and Adverse Occurrences** • #2., Added "business" to 2nd paragraph language for clarification. Also, added new language to end of 10th bullet. **O. Contact Us** • Removed language (last paragraph) for the primary care provider consultation line.
XVI. Provider Networks	331-342	• Updated language within each sub-section with the exception of the following: "D. Provider Termination Appeal Process", and "H. Professional Provider Contracting – Practice Type".
XVII. Credentialing	344 346 347-350 351-355	**A. Introduction** • Removed language in 6th & 7th paragraphs regarding Credentialing Committee peer review and Discretion policy. **C. Credentialing Policies** 1. Credentialing Process for Practitioner: Medical and Behavioral • Section 5, Hospital Affiliations – Updated language for Admitting arrangements. • Updated list of practitioner specialties' requirements, as applicable. 2. Credentialing Process for Medical & Behavioral Health Organizational Providers • Updated list of organizational providers' requirements, as applicable.
XVIII. CoverKids	389 389 390 390	**G. Utilization Management** • Outpatient Services – Removed "Sleep Studies…under age of 6 years" from the bulleted list (2nd bullet). • DME – Added new language as 1st paragraph as of. 3/6/26 regarding DME network transition to CareCentrix and phone. • Equipment Providers – Removed language in 2nd paragraph eff. 2/1/24, regarding incontinence supplies vendor and contact. And removed vendor reference "HCD" from 2nd Note language. • Respiratory Care Supplies & Equipment Providers – Removed title and language.
XIX. Provider Audit Guidelines	394	**B. Audit Process** • Audit Accommodation – Added language to end of 1st paragraph and as last paragraph of this sub-section.
XX. TennCare Kids	409	**D. Coordination of Care** • School Based Nursing Services, 3rd paragraph – removed "Effective September 1, 2025" from beginning of paragraph.
XXII. LTSS	431 442-448	**C. Benefits** • **2. Exclusions -** Updated hyperlinks **F. Provider Agreement Requirements** • Definitions List: Removed MLTSS, Under Religious and Ethical Directives - added language to 2nd paragraph, and under TennCare CHOICES – added 2nd and 3rd paragraph language, within first numbered list - updated

Section # and Title	Affected Page(s)	Modification
XXII. LTSS (Cont'd)		hyperlinks in #11, within second numbered list - updated language in #16 and #17. **G. Provider Contracting/Credentialing**
	453&455	• Within numbered list – added language to #6, removed "MLTSS" from language within last two paragraphs before "Credentialing Requirements for CHOICES Providers".
		H. Billing and Reimbursement
	466	• Within Level 2 – HCBS grid: Removed "(Cont'd)" from In-patient respite care
		K. General Information (CHOICES and Katie Beckett Part A)
	470-471	• 2. Reportable Event Management o Updated language on how providers with and without access to the PERLSS system are required to submit Reportable Events.
Attachment II. THCII		• Within grid, updated:
	552	o hyperlink for "Tennessee Health Care Innovation Initiative Guide to How to Read Your Episode of Care Report"
	553	o Quality Metrics – Replaced "Detailed Business Requirements" with "Executive Summary"
	554	o THCII Provider Dispute Resolution Process – Removed language and link for Commissioner of Commerce for Independent Review of Disputed TennCare Claim form and updated remaining language.

BlueCare Tennessee

Provider Administration Manual

For BlueCare℠, TennCare*Select* and CoverKids Networks

BlueCare Tennessee

Effective July 1, 2026

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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, ethnic/national identity, age, sex, religion, patient type (e.g. Medicaid) or disability in any health program or activity. 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 https://bluecare.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®, CoverKids, and TennCare*Select* operating policies and procedures. The information contained in this Manual applies to Providers who care for BlueCare Tennessee 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." In addition, as a participant in a program receiving federal funds, Providers shall not be subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

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

Updates to Medical Policy Manual on company websites, www.bcbst.com or http://bluecare.bcbst.com.

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/Outreach-and-Education

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:

A. 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.

B. 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* as their TennCare MCO; TennCare members assigned to the TennCare*Select* MCO must meet certain criteria and must be assigned to the TennCare*Select* MCO by the Division of TennCare. For example. TennCare assigns enrollees meeting the following criteria to the TennCare*Select* MCO: children receiving Social Security Insurance benefits; children who are in state custody; 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 four sub-programs. The programs are known as CHOICES, ECF CHOICES, *Select*Community, and Katie Beckett Program Part A, which the following more fully describes:

Enhanced Services Programs:

C. CHOICES Long-Term Services and Support (LTSS)

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.)

D. 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 the Managed Long-Term Services Manual (MLTSS) for more detailed information.)

E. *Select*Community (TennCare*Select* only)

The Division of TennCare established a TennCare*Select* program for certain persons with Intellectual Disabilities called *Select*Community. 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 *Select*Community 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. *Select*Community in this Manual for more detailed information).

F. Katie Beckett Program Part A (TennCare*Select* only)

TennCare and the Department of Disability and Aging (DDA) established a new standalone Katie Beckett Program. The Katie Beckett Program is for children up to the age of 18 to get care for their disability or medical needs, even if their parents' income is higher than Medicaid usually allows. It helps families care for children in their own home rather than a hospital or institution.

Katie Beckett Program eligibility is determined, in part, by a medical review called a Pre-Admission Evaluation (PAE) that determines the "level of care" a member needs from the Katie Beckett Program. Levels of care are based on a thorough review of the member's medical needs, behavioral needs, and functional needs.

There are two levels of care for Katie Beckett: 1. Institutional level of care – for children who would qualify to receive care in a medical institution—like a hospital, nursing home, or ICF/IID (intermediate care facility for individuals with intellectual disabilities), but want care at home, and, 2. At Risk level of care—for children who don't qualify to receive care in a medical institution, but are "at risk" of needing institutional care unless they can get care at home.

Katie Beckett Program Part A is for children with the most significant disabilities or complex medical needs. These are children who would qualify to receive care in a medical institution but want to receive care at home. Children in Katie Beckett Program Part A are not Medicaid eligible due to their parents' income or assets but will receive full Medicaid benefits based on their complex medical and behavioral needs. These children must have a primary payer or third-party liability (TPL) that will be their first payor with Medicaid paying secondary. Children in Katie Beckett Program Part A can also receive up to $15,000 a year in home and community-based services to help pay for things insurance usually doesn't cover.

Children in Katie Beckett Program Part A will have TennCare*Select* for their health plan (managed by BlueCare).

G. 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, dental care, and vision care. CoverKids does not cover any chiropractic, routine vision, or 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 was supported by the CoverKids Network. Effective January 1, 2021, CoverKids is supported by the BlueCare Network. (See Section XVIII. CoverKids in this Manual for more detailed information.)

A map defining the Grand Regions and important contact numbers follow:

BlueCare (East, West/Middle Grand Regions)		**TennCare*Select* (Statewide)**	
Member Service Line	1-800-468-9698	Member Service Line	1-800-263-5479
Provider Service Line	1-800-468-9736	Provider Service Line	1-800-276-1978
Fax	1-800-357-0453 or 1-423-535-7111	Fax	1-800-218-3190 or 1-423-535-6399
Prior Authorization for Medical and Behavioral Health (statewide)		Prior Authorization for Medical and Behavioral Health (statewide)	
Phone	1-888-423-0131	Phone	1-800-711-4104
Fax	1-800-292-5311	Fax	1-800-292-5311
Provider Initiated Notices (Behavioral Health)	1-800-859-2922	Provider Initiated Notices (Behavioral Health)	1-800-859-2922
Special Kids	N/A	Prior Authorization for Medical and Behavioral Health	
		Fax	1-800-292-5311
Individual Education Plan (IEP)		Individual Education Plan (IEP)	
Fax	1-855-876-1494 or 1-423-591-9395	Fax	1-855-876-1494 or 1-423-591-9395
Utilization Management (UM) Enhanced Respiratory Care (ERC) Services for Non-CHOICES)		Utilization Management (UM) Enhanced Respiratory Care (ERC) Services for Non-CHOICES)	
Phone	1-888-423-0131	Phone	1-888-423-0131
Fax	1-423-591-9398	Fax	1-423-591-9398

BlueCare (East, West/Middle Grand Regions)		**TennCare*Select* (Statewide)**	
Claims Mailing Address: BlueCare 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002		Claims Mailing Address: TennCare*Select* 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002	
CHOICES /ECF CHOICES		***Select*Community**	
Provider Inquiry Specialists for EVV Missed/Late Visits All Other Inquiries	1-888-747-8955 1-800-468-9736	All Inquiries Phone Fax	 1-800-292-8196 1-888-255-9175
Enhanced Respiratory Care (ERC) Services for CHOICES, Non-weaning Phone E-mail: Enhanced Respiratory Care (ERC) Services for CHOICES, Vent-weaning, sub-acute tracheal suctioning Phone Fax Claims Mailing Address: CHOICES/ECF CHOICES 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002 Claims Mailing Address: CoverKids 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002	 1-888-747-8955 CHOICESNFForms_GM@bcbst.com 1-888-423-0131 423-535-7790	Enhanced Respiratory Care (ERC) Services for CHOICES, Non-weaning Phone E-mail: Enhanced Respiratory Care (ERC) Services for CHOICES, Vent-weaning, sub-acute tracheal suctioning Phone Fax Claims Mailing Address: *Select*Community 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002	 1-888-747-8955 CHOICESNFForms_GM@bcbst.com 1-888-423-0131 423-535-7790
Member Service Line Provider Service Line Prior Authorization for Medical and Behavioral Health Phone Fax	1-888-325-8386 1-800-924-7141 1-800-924-7141 1-800-851-2491		

Copayment Structure effective January 1, 2024, and after

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.)

Poverty Levels	Copayment Amount
0 – <134%	$0.00
134% - 199%	$8.20, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care* $5.00, Physician Specialists (including Psychiatrists) $5.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $15.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care* $20.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)

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

Copayment Structure effective January 1, 2022, through December 31, 2023

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.)

Poverty Levels	Copayment Amount
0 – 99%	$0.00
100% - 199%	$8.20, Hospital Emergency Room (waived if admitted) $5.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care* $5.00, Physician Specialists (including Psychiatrists) $5.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)
200% and above	$50.00, Hospital Emergency Room (waived if admitted) $15.00, Primary Care Provider (PCP) and Community Mental Health Agency services other than preventive care* $20.00, Physician Specialists (including Psychiatrists) $100.00, Inpatient Hospital Admission (waived if readmitted within forty-eight (48) hours for the same episode)

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

Copayment Structure prior to January 1, 2022

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.)

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

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

C. General Information

1. Nondiscrimination Requirements

As a TennCare provider you interact with individuals from diverse cultural backgrounds, including, individuals with Limited English Proficiency (“LEP”), individuals with low literacy, individuals with disabilities with vision, cognitive, hearing, and speech disabilities, TennCare and the federal health care regulations require recipients and subrecipients (providers) of federal funds to have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner and to train staff on these policies and procedures. Besides having a general nondiscrimination policy, your organization must have policies for providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and procedures for regularly inspecting assessment methods and decision support tools like algorithms to promote equal outcomes and eliminate bias with generating results. This instruction shall include a component on providing cultural linguistically appropriate services (“CLAS”) that must include education on the potential impact of linguistic and cultural barriers on utilization, quality, and satisfaction with care and how to deliver CLASs appropriately during a service encounter.

As required by 42 CFR 438.206, BlueCare and its Providers and Subcontractors that are providing services to TennCare members must 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 sex. To meet this requirement, interpreter services must be available through telephonic and/or in-person interpreters, video-remote interpreting, Communication Access Realtime Translation (CART) providers, oral transliterators, cued-language transliterators, deaf-blind interpreters. American Sign Language and International Sign Language interpreters,

as well as qualified mental health interpreters. In addition, TennCare Providers must have the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

Language and communication assistance services ("LCAS") ensure that you can effectively communicate with your patients who may be aging, Limited English Proficient, or an individual with a disability. LCAS include language interpretation (includes sign language) and translation services and auxiliary aids or services like providing a document in an alternative format like large print for any member and/or the Member's representative who needs such services. The financial responsibility for the provision of the requested LCAS 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.

Providers can use the "I Speak" Language Identification Poster (ISpeakPoster, https://www.dhs.gov/xlibrary/assets/crcl/crcl-i-speak-poster.pdf) to identify the primary language of BlueCross BlueShield of Tennessee Members, including BlueCare Tennessee Members.

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
- Tennessee Language Center 1-615-741-7579

Providers may also consider:

- Training bilingual staff
- Utilizing telephone and video services
- Using qualified translators and interpreters
- Using qualified bilingual volunteers

If you, the Provider needs language assistance services in a language other than English, please call BlueCare at 1-800-468-9736, CoverKids at 1-888-325-8683 or TennCare*Select* at 1-800-276-1978. Necesita ayuda con el idioma gratuita? Llame BlueCare 1-800-468-9736, CoverKids 1-888-325-8683, TennCare*Select* 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.).

2. Health Literacy and Cultural Competency Provider Tool Kit

Cultural Competent organizations utilize policies and have trained and skilled employees and resources to anticipate, recognize and respond to various cultural backgrounds (language, age and religion) of Members and health care Providers. Health and human service Providers must be prepared to operate in cross-cultural contexts. Proper preparation is necessary for delivering high quality care that effectively prevents, identifies, and treats a wide variety of health conditions.

BlueCross BlueShield of Tennessee offers a Non-discrimination Compliance Training presentation to equip health care professionals with additional resources for delivering care to 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. Once the training is complete, please complete the Cultural Competency Training Attestation Form at http://bluecare.bcbst.com/forms/Provider%20Forms/Cultural_Competency_Training_Attestation_Form.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
TennCare*Select*	1-800-711-4104
CHOICES/ECF CHOICES	1-888-747-8955
*Select*Community	1-800-292-8196
CoverKids	1-800-924-7141

- Crisis Services

State of Tennessee crisis hotline	1-855-274-7471
National Suicide and Crisis Lifeline	988

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. 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. 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 health care.
- **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.
- **Health care 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.

Interoperability Standards and the HITECH Act

Providers are encouraged to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with Public Law 115-5, The Health Information Technology for Economic and Clinical Health (HITECH) Act.

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.

Providers and subcontractors 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 Division (MFCD), 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.

Providers and subcontractors shall conduct background checks in accordance with state law and TennCare policy. At a minimum, criminal background, registry, and exclusion checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, the List of Excluded Individuals/Entities (LEIE), Excluded Parties List System (EPLS). The System for Award Management (SAM), and TennCare’s Terminated Provider List. The FEA shall be responsible for conducting all mentioned background checks on its staff, its subcontractors, and consumer-directed workers.

Providers and subcontractors 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 Medical Fraud Control Division 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 https://www.bcbst.com/fraud/;
- Call the OIG from anywhere in Tennessee at 1-800-433-3982; or

Log onto https://www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html.

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 $14,308 and not more than $28,619 (eff. 1/15/2025)
- 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
- 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.
7. Additional information regarding fraud, waste and abuse can be found on the Centers for Medicare & Medicaid (CMS) website at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/providercompliance.html.

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 Documents & Forms | BlueCare Tennessee, then click on "Authorizations and Appeals", and then "Appeals and Reconsiderations".

APPEAL TYPE	APPEAL REQUESTER	APPEAL ADDRESS
Member Appeal – Delays, denials, reduction, suspension, or termination of services for Members. Note: Services have NOT been rendered. **(See Section VII. E. Member Appeals)**	Member	**Call** TennCare at 1-800-878-3192, Monday through Friday during the hours of 8 a.m. to 4:30 p.m., Central Time. **Fax** the TennCare Medical Appeal form for free to 1-888-345-5575. **Mail** the TennCare Medical Appeal form to: TennCare Member Medical Appeals P.O. Box 000593 Nashville, TN 37202-0593
Clinical Provider Appeal - Not Medically Necessary denials, e.g., admissions, facility continuation care, and elective surgery Note: Services have been rendered.	Provider	BlueCare Tennessee Appeals Department Attention: (BlueCare/TennCareSelect, CoverKids, CHOICES/ECF

APPEAL TYPE	APPEAL REQUESTER	APPEAL ADDRESS
(See Section VIII. L. Utilization Management Provider Appeals Process)		CHOICES) UM Appeals Department (specify) Fax Number 1-888-357-1916
Reconsideration (1st Level Appeal) - Issues regarding claims, accounts receivable, denials for non-covered services, and member benefits. **(See Section XII. A. Reconsideration (1st Level Appeal). In-state providers are required to file Reconsiderations through Availity effective 01/01/2026. Out-of-state providers should submit Reconsiderations to this address**.	Provider	BlueCare Tennessee/BCBST Provider Appeals Coordinator Provider Network Management 1 Cameron Hill Circle Ste 0007 Chattanooga, TN 37402-0007
Provider Dispute - Denials that are upheld through the above noted processes may be submitted through the Provider Dispute Resolution process. (Same as above) ***(See Section XII. B. Provider Dispute Resolution Process)***	Provider	BlueCare Tennessee/BCBST 1 Cameron Hill Circle Ste 0039 Chattanooga, TN 37402-0039

Note: For issues concerning CoverKids eligibility, Members can call TennCare Connect at 1-855-259-0701. See Section XVIII. CoverKids in this Manual to review eligibility Criteria.

E. Important Contact Information

Contact	Toll Free/Local Number	Address/Description
Provider Enrollment:		
Credentialing	1-800-924-7141	Credentialing e-mail: credentials@bcbst.com
General Information	1-800-924-7141	Contracting e-mail: Contracts_Regs_GM@bcbst.com 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 PEF, demographic changes (non-par), returned mail or checks. To provide supporting documentation for a submitted enrollment form or for online enrollment process issues, e-mail: ProviderSupport@bcbst.com eBusiness e-mail: eBusiness_Service@bcbst.com

Contact	Toll Free/Local Number	Address/Description
Provider Service Lines: BlueCare TennCare*Select* CHOICES/ECF CHOICES *Select*Community CoverKids	 1-800-468-9736 1-800-276-1978 1-800-468-9736 1-800-292-8196 1-800-924-7141	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
Provider Networks & Contracting/Provider Relations: Statewide	 1-800-924-7141 Option 1	 BlueCare Tennessee/BCBST ATTN: Provider Networks & Contracting/Provider Relations 1 Cameron Hill Circle, Chattanooga, TN 37402
NurseLine: Health Information and Education Health Care Counseling Telephone Triage BlueCare/TennCare*Select*/ CoverKids	 1-800-262-2873	Direct Line available 24-hours-a-day, 7-days-a-week
TennCare	Phone: 1-800-878-3192 Fax: 1-888-345-5575	TennCare Member Medical Appeals P.O. Box 593 Nashville, TN 37202-0593
TennCare Pharmacy Program (Prior Authorizations) BlueCare/TennCare*Select*/ CoverKids	 Fax 1-844-403-1029	OptumRX (Submit prior authorization requests only via Fax or electronically through "Covermymeds" at https://account.covermymeds.com/
Dental	Phone 1-866-864-2526 **NOTE**: Eff. Nov. 1, 2025, Renaissance is the new Dental Benefits Provider.	Renaissance P.O. Box 1596 Indianapolis, IN 46206
eBusiness Solutions Technical Support (Availity, Electronic billing, EFT, ERA)	Phone 1-423-535-5717 Option 2	BlueCross BlueShield of Tennessee eBusiness Solutions 1 Cameron Hill Circle Chattanooga, TN 37402
Fraud & Abuse Hotline BlueCross BlueShield of Tennessee Division of TennCare	 Phone 1-888-343-4221 Phone 1-800-433-3982	To report suspected fraudulent activity.

Contact	Toll Free/Local Number	Address/Description
Tennessee Bureau of Investigation Medicaid Fraud Control Division	Phone 1-800-433-5454	
Office of Inspector General	Phone 1-800-433-3982	
Population Health Management ➢ Wellness, prevention, health promotion ➢ Care Coordination ➢ Rising risk and chronic care ➢ Low Risk Maternity ➢ High Risk Maternity ➢ Complex Case Management	Phone 1-888-416-3025 Fax 1-800-421-2885	
Home Health/PDN Missed Visit Reporting Line **BlueCare/TennCare*Select***	Fax 1-833-744-7587 1-423-535-1931 Availity	Report non-covered Visits greater than one (1) hour within three (3) calendar days
Tennessee Health Connection	Phone 1-855-259-0701	Tennessee Health Connection P.O. Box 305240 Nashville, TN 37230-5240
BlueCare	Fax 1-800-919-9213	To arrange behavioral health services
Inpatient/Outpatient Behavioral Health	Phone 1-888-423-0131 Fax 1-800-292-5311	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.
Provider Initiated Notices	Fax 1-800-859-2922	
TennCare*Select*	Phone 1-800-711-4104 Fax 1-800-292-5311	To arrange behavioral health services
Inpatient/Outpatient Behavioral Health		To arrange medical/behavioral health services
Provider Initiated Notices	Fax 1-800-859-2922	
Individual Education Plan (IEP)	Fax 1-855-876-1494 Fax 1-423-591-9365	
CHOICES/ECF CHOICES	Phone 1-888-747-8955	
State of Tennessee Crisis Hotline		To obtain immediate assistance in a crisis situation.
Adults (18 years and older)	1-855-274-7471	To arrange emergency crisis services

Contact	Toll Free/Local Number	Address/Description
Children & Youth (under 18 years of age): Memphis Region Rural West TN Rural Middle TN Nashville Region Upper Cumberland Southeast TN Knoxville Region Northeast TN	1-800-690-1606 1-866-791-9226 1-866-791-9227 1-866-791-9222 1-866-791-9221 1-866-791-9223 1-866-791-9225 1-866-791-9224 1-866-791-9228	
Primary Care Provider Consultation line **Non-emergency Transportation:** BlueCare Statewide TennCare*Select* Statewide CHOICES/ECF CHOICES *Select*Community	1-877-241-5575 1-855-735-4660 1-866-473-7565 1-888-747-8955 1-800-292-8196	Staffed by Behavioral Health Peer Advisors, (Board Certified Psychiatrists). Line is available Mon – Fri, 9 a.m. to 5 p.m. (ET) Verida, Inc. 5600 Brainerd Road, Suite H-100 Chattanooga, TN 37411 Non-emergency transportation services are provided for: BlueCare, TennCare*Select*, CHOICES, ECF CHOICES, Katie Beckett Program Part A and *Select*Community Members to and from their physical and behavioral health care services.

F. BCT Contract Quick Reference Guide

Contact	Contract Address	Description
Provider Contract Management	BlueCross BlueShield of TN Attention: Provider Contract Management 1 Cameron Hill Circle Chattanooga TN 37402	Unless otherwise stated in your provider's contract, all notices should be sent to this address.
Legal Department	GM,LegalProviderContracts@bcbst.com	Copies of all notices, not constituting notice, must be sent to our Legal Department.

Providers should send notices to their Network Manager. To find out who your Network Manager is, please use the online self-service look up tool located at https://provider.bcbst.com/contact-us/my-contact or call the Provider Service Line at 1-800-924-7141.

G. Registering or Updating Your Provider Contract Address

If you haven't registered to receive real-time information about your contract, log on to Availity and provide us with your contract address:

1. Go to http://www.Availity.com
2. Click on "Register" in the upper right corner of the home page
3. Select "Providers"
4. click "Register"
5. Follow the instructions in the registration wizard.

If you have already registered and need to update your contract address:

Please follow the step-by-step instructions outlined below.

Balance this Page Intentionally Left Blank

How To Update Your Contact Preference in Availity

As you work hard to care for our members, we're also working hard to make sure you get important information quickly and efficiently. That's why we're expanding provider access to electronic communications. Users must request permission from their Availity administrator for access to view and update communication types.

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1 Using your internet connected device open your web browser of choice. Navigate to the Availity web page using the web address **www.apps.availity.com**.

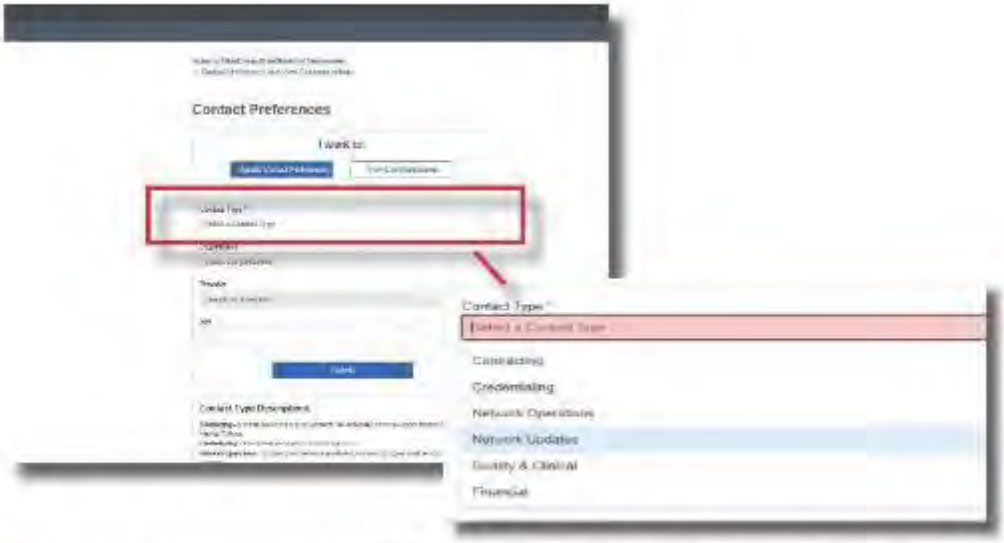
2 After successfully navigating to the web page listed above the user will be presented with a login page. Use your Availity login and password to proceed. If this is the first time logging into Availity from this device the user will receive a second authentication step. The user will be given a choice on how to enter a code that was previously supplied or one that is sent through text.

3 Once successfully logged into Availity the user will be presented with their Availity home page. The user will navigate to the **BCBST Payer Space**. To Navigate to the BCBST Payer Space the user will click the Payer Spaces Menu item and the BCBST icon.

4 Select the **Contact Preferences & Communication Viewer** tile.

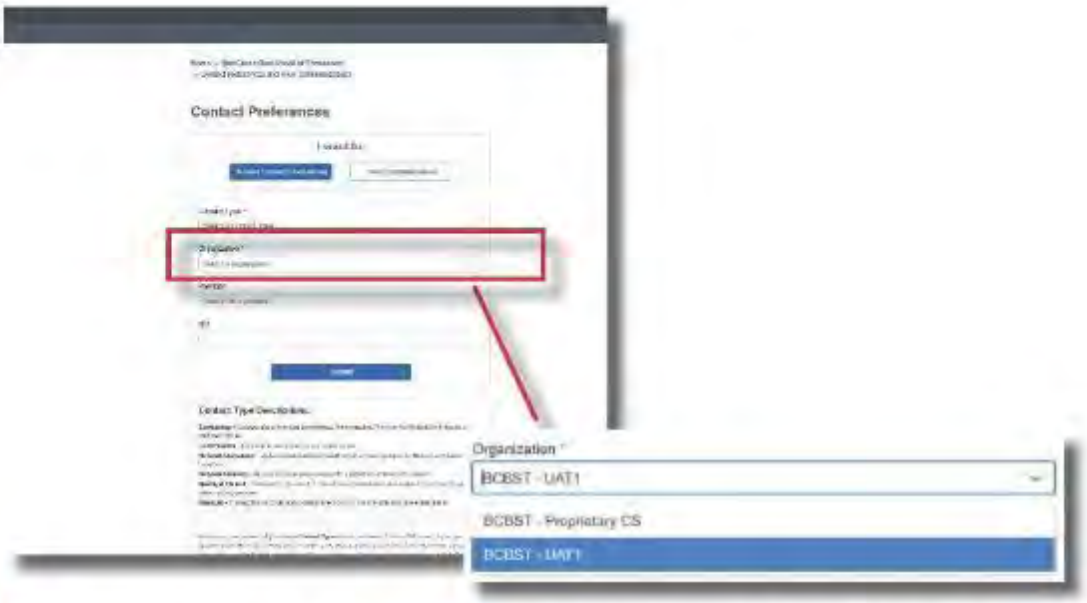
5 To update Contact Preferences choose **Update Contact Preferences.** The button will turn blue when selected.

6 Select **Contact Type***.



Contracting – Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies | **Credentialing** – Information about your credentialing status | **Network Operations** – Updates about network enrollment and your listing in the BlueCross Provider Directory | **Network Updates** – General business announcements, newsletter updates and surveys | **Quality and Clinical Information** – Notifications of available clinical data, performance and payment reporting for our value-based programs | **Financial Updates** – Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items

7 The user must then select the desired **Organization**.



8 If the contact type selected is **Contracting** the user may proceed to step 9 or skip to step 10 if they would prefer to see all contracts associated to the selected organization . **This step is for Contracting only. For all other Contact Types except for Contracting proceed to step 9.**

9 If the contact type is not Contracting the user is required to either select a provider from the provider drop down or manually enter an NPI. If contracting contact type is selected provider and NPI is not required but may be entered to narrow down the contracts retrieved. After the correct provider has been selected click "submit".

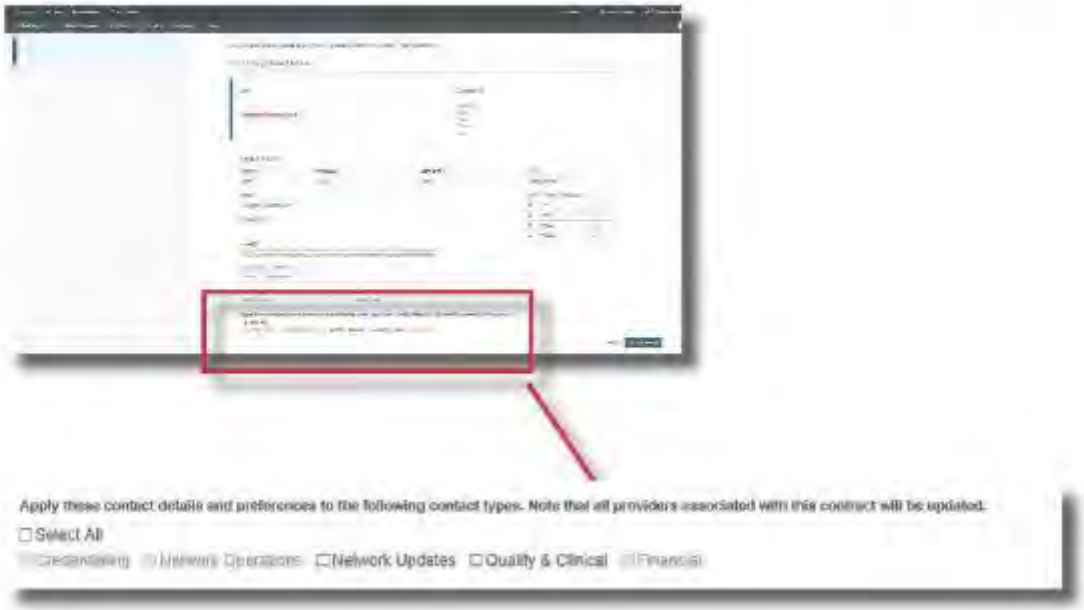
10 While the application retrieves information the user will be presented with a Fetching Contacts message on the screen. Please do not hit refresh or back button during this time.

11 On the left side of the page the user can select different tabs to view the contracts associated to their organization. By default the first contract is selected and displayed. The user may click on the desired contract to review, update, or insert the contact information for the selected contract.

12 After reviewing the contract information the user can select the **Update Contact Information** button to update any information required for this contact. **Note:** The Provider Enrollment and Contracting role is required for the user to be able to update or insert contact information. Users may request this role from their Availity Administrator

13 This will load a similar screen but with the added ability to update the specific contact information. The user can confirm which provider or contract they are updating information for by checking the tabs on the left side (the selected tab will be a light blue color) of the screen as well as the information before the update section.

14 Users can apply the same updated contact details to other Contact Types by **checking the Contact Type boxes** – or the **Select All box** (which automatically checks all Contact Types you have access to.)



15 Click "Save & Submit" when finished. Once the opt-in to email is selected this will need to be maintained to ensure providers receive all communications in a timely manner.

Need Help?

If you have questions or need help with Availity, please visit Availity.com or contact our eBusiness Service team at **(423) 535-5717 (option 2)** or to reach Provider Network Services call the Provider Service line at **1-800-924-7141 (Contracting & Credentialing Option).**

II. How to Identify a BlueCare Tennessee Member

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.

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. This site will take them to either the Marketplace or to TennCare to be approved for continued enrollment in TennCare.

When a BlueCare or TennCare*Select* 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 or by calling 1-800-852-2683. Providers may also call BlueCare at 1-800-468-9736 or TennCare*Select* 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 TennCare*Select* 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 <u>may</u> 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 <u>may not</u> 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 TennCare*Select* 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:

Front

Back

Sample copy of the TennCare*Select* Member ID card (Standard or Medicaid) follows:

Front

Back

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

- Checking his or her most recent online BlueCare/TennCare*Select* 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
TennCare*Select*	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:

BPI	Eligibility Description	Pharmacy Description
A	A child under age 21, who does NOT have Medicare. (May include CHOICES – Nursing Facility Only)	As Medically Necessary
B	A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who does not get long-term care (CHOICES)	5 Prescriptions (2 Brand, 3 Generic)
C	A TennCare Standard adult age 21 and older	No Pharmacy Benefits
D	A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who is Medically Needy (Spend Down)	5 Prescriptions (2 Brand, 3 Generic)
E	A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who gets long-term care other than CHOICES	As Medically Necessary
F	A TennCare Medicaid adult age 21 and older who has Medicare, and does NOT get long-term care (CHOICES),	No Pharmacy Benefits
G	A TennCare Medicaid adult age 21 and older who has Medicare, and gets long-term care other than CHOICES	No Pharmacy Benefits
H	A child under age 21 who has Medicare (May include CHOICES – Nursing Facility Only)	Wrap Around Coverage Only
I	Undocumented Alien – Certain Maternity or Emergency services only	No Pharmacy Benefits
J	A TennCare Medicaid adult age 21 or older who does NOT have Medicare and is enrolled in CHOICES	As Medically Necessary
K	A TennCare Medicaid adult age 21 or older who has Medicare and is enrolled in CHOICES	No Pharmacy Benefits

TennCare eligibility classification is defined as:

Classification Number	Classification Type	Medicaid/Standard
17	Medicare/Medicaid Dual Eligible	Medicaid
27	Uninsurable/Disabled	Standard
37	Disabled Uninsured	Standard
47	Disabled Medicaid	Medicaid
67	Medicaid Other	Medicaid
77	Uninsured/Disabled with Medicare	Standard
87	Uninsured Other	Standard
97	Uninsurable	Standard

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., a condition that limits intelligence and disrupts abilities necessary for living independently) 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/TennCare*Select* 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
TennCare*Select*	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 TennCare*Select* 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.

- Submit claim files through the SFG website:

  https://mftweb.bcbst.com/myfilegateway

- Instructions for how to use SFG are below:

https://www.bcbst.com/providers/ecomm/BCBST_SFG_Instructions.pdf

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.

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III. Primary Care Member Assignment

(Effective 1/1/21, this section applies to CoverKids)

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 on your roster, please refer to the **Member/Practitioner Relationship Termination** section of this document.

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:

Field	Description
Report Type	Added Members Since Last Report, Current Members, Members Transferred from Provider, or Dropped Members
Provider ID	Provider ID
Line of Business	Line of Business (BlueCare, BlueCare Plus, TennCare*Select,* CoverKids or *Select*Kids)
Member Name	Member name. The names are listed alphabetically by the first name.
Member Address	Address of assigned member
Phone	Telephone number of assigned Member
Sex	Member's gender
DOB	Date of birth
SSN	Social Security Number
Member ID	ID Number of Member
Member Old ID	Old Member ID if applicable
Copay	Member's Copay Code
EPSDT	TennCare Kids Visit past due
Effective Date	Effective Date of Coverage
Future Disenroll Date	Future Disenrollment Date with PCP Termination Date
Effective With PCP	Effective Date with PCP

B. TennCare*Select* Care Management Fee

In addition to routine service fees, TennCare*Select* Primary Care Providers (PCPs), which include Best Practice Network and *Select*Community 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 TennCare*Select* 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 TennCare*Select* PCPs who reach and maintain a combined assignment of 300 BlueCare and TennCare*Select* members.
3. BlueCare and TennCare*Select* Members.
   Compensation paid when a minimum[1] of 300 Members are assigned, up to a maximum of 1,500 Members per TennCare*Select* Primary Care Provider (TennCare*Select* PCP Physician Extenders are limited to a maximum of 1,250 assigned Members and paid the care management fee accordingly).
4. TennCare*Select* Care Management Fee payment eligibility is reviewed quarterly; TennCare*Select* 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

TennCare*Select* 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 TennCare*Select* 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.

[1]There is no minimum enrollment criteria for Best Practice Network and *Select*Community Providers.

[2] Best Practice Network and *Select*Community 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, for BlueCare/TennCare*Select* Providers and effective January 1, 2021 for CoverKids, 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/TennCare*Select*/CoverKids Customer Service line;
- Member mails in written PCP change request to BlueCare/TennCare*Select*/CoverKids Customer Service;
- Member mails postage-paid PCP Change Card to BlueCare/TennCare*Select*/CoverKids (cards are available in BlueCare/TennCare*Select*/CoverKids Member Handbook); or
- Provider or provider's designated staff change a member's PCP assignment using the BlueCare PCP Maintenance Application located in Availity, the secure area on the company websites: http://bluecare.bcbst.com and https://www.bcbst.com/

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.
- The preferred method of changing a member's PCP is through the BlueCare PCP Maintenance Application located in 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.
- Information related to PCP changes can be found in the Quick Reference Guide located in the Payers Spaces section within Availity.
- If a PCP wants to change his/her patient acceptance criteria, he/she must submit a request to the Provider Management Department. This request can be submitted by logging into Availity or by submitting a change on the PCP's letterhead.

  Mail to:

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

- 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.

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IV. Benefits

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

A. Covered Benefits

The following sections describe the services and supplies available under BlueCare and TennCare*Select* 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: BlueCare does not make a secondary payment on items or services that are covered by Medicare and will never pay above the patient responsibility amount listed on a commercial payer's Explanation of Benefits.

1. 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

2. Physician Services (Inpatient)

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

4. 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 $8.20 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.)*

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.

5. Surgical/Medical Services

Surgery

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

Special Surgery

- Organ and Tissue 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

6. 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

7. 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

8. 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.

9. Diagnostic Services

X-rays, laboratory examinations and other diagnostic services

10. Newborn Services

As Medically Necessary including circumcisions performed by a Practitioner.

Note: Lactation consultant services are a covered benefit. Please see 12. Maternity Services below for additional information.

11. Physical Services

Benefits are provided for services rendered by a physiotherapist

12. 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 ARE COVERED WHEN THE ABORTION IS A LIFE ENDANGERING PHYSICAL CONDITION ARISING FROM THE PREGNANCY ITSELF THAT WOULD PLACE THE MOTHER IN DANGER OF DEATH. ABORTIONS ARE A COVERED SERVICE ONLY WHEN THE GUIDELINES LISTED BELOW ARE MET PERSUANT TO APPLICABLE FEDERAL AND STATE LAWS. A CERTIFICATE OF MEDICAL NECESSITY MUST BE COMPLETED BY THE PHYSICIAN AND ATTACHED TO THE CLAIM SUBMITTED TO BlueCare Tennessee FOR PAYMENT.

Note: Effective June 1, 2023, your patients with BlueCareSM, TennCare*Select* or CoverKids coverage have lactation consultant benefits. These benefits include medically appropriate lactation consultant services from in-network providers during pregnancy and the extended postpartum period. Parents can receive services through telehealth or in-person in a one-on-one or small group setting. There's no limit on the number of visits allowed, but we may request additional information after 15 units are billed. Services should be billed as indicated below:

CPT Code	Description
98960 U8	Single individual per 30 minutes
98961 U8	2-4 patients per 30 minutes
98962 U8	5-8 patients per 30 minutes

13. 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

14. Diapers Benefit

Effective August 7, 2024, your patients' with BlueCare Tennessee or CoverKids coverage have access to diapers and training pants at no cost to them. The benefit covers up to 100 diapers per month from an approved list of products until age 2. To view the list of participating pharmacies and approved diapers, which include different types and brands, please visit tn.gov/tenncare/diapers.

To get the diapers, parents and guardians will need to present their child's pharmacy ID card at the pharmacy counter of participating locations. There's nothing required from you. Patients don't need a prescription, and diapers don't have a copay or count against our members' monthly prescription limit. If a newborn doesn't have a pharmacy ID card yet, parents can present the mother's pharmacy ID card or the child's Social Security Number.

15. Preventive Services

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

16. 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;
- 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.

17. Obesity Services

- **Incretin-based weight management therapies** (e.g., GLP 1 receptor agonists) prescribed for chronic weight management (obesity) are a covered benefit when coverage criteria are met. Coverage is subject to TennCare pharmacy requirements, including preferred status, prior authorization, clinical criteria, and quantity limits in the TennCare Preferred Drug List (PDL) administered by OptumRx located at the following site: https://www.optumrx.com/oe_tenncare/landing. Please see 22. Prescription Drugs for additional information.
- For Members receiving incretin-based weight management medications for the treatment of obesity, wraparound supports are recommended to support safe, effective, and sustainable care.
    - BlueCare offers an **integrated care team** that provides coaching and care coordination as part of its Population Health Management approach. Refer to Section X. Population Health Management Program, A. 2. Helping members manage their own health risks.
    - **Referral to a Registered Dietitian (RD**) may be appropriate for patients initiating incretin-based weight management therapy, experiencing side effects, or encountering nutrition-related barriers. Medical Nutrition Therapy (MNT) is a covered benefit when medically necessary and billed in accordance with TennCare policy. Refer to Section V. Billing and Reimbursement.
    - **Behavioral health conditions**, including disordered eating, are prevalent among individuals with obesity and can affect treatment safety and outcomes. Routine screening enables early identification and timely referral for appropriate care. The following list provides evidence-based screening tools for use by physicians and other medical providers. Screening tools are not diagnostic and are intended to identify patients who may require further clinical assessment or referral. A positive screen should prompt clinical assessment and/or referral to appropriate services (e.g., behavioral health, eating disorder specialist). Providers may identify appropriate in network behavioral health providers by accessing the BlueCare Provider Directory at https://www.bcbst.com/get-care/find-care and selecting Behavioral Health or Mental Health specialties, including psychiatrists, psychologists, and licensed therapists (e.g., LCSW, LPC, LMFT), and refining by keywords (e.g., disordered eating, anorexia, bulimia, binge eating disorder) when available. Telehealth behavioral health services may be utilized for mild to moderate needs, with referral to in person or higher levels of care when clinically indicated.

Name of Screen	Description	Scoring / Interpretation	Accuracy	Time Frame	Typical Clinical Setting(s)
SCOFF Questionnaire https://www.bmj.com/content/319/7223/1467.full	Brief screening tool designed for non-specialists to identify possible eating disorders, primarily	≥2 positive responses indicate a positive screen requiring	Sensitivity ~100% for anorexia nervosa and bulimia nervosa;	5 yes/no questions (~1 minute)	Primary care; internal medicine; OB/GYN; endocrinology; obesity medicine;

	anorexia nervosa and bulimia nervosa.	further assessment.	specificity ~85–90%.		pre-GLP-1 screening
Eating Disorder Screen for Primary Care (ESP) https://pmc.ncbi.nlm.nih.gov/articles/PMC1494802/	Primary-care–specific screening tool to identify risk of eating disorders.	Any abnormal response indicates a positive screen requiring evaluation.	Demonstrated good sensitivity in primary care populations.	5 yes/no questions (~1–2 minutes)	Primary care; family medicine; preventive care visits
BEDS-7 (Binge-Eating Disorder Screener) https://eprovide.mapi-trust.org/instruments/7-item-binge-eating-disorder-screener	Condition-specific screener for probable binge-eating disorder.	Weighted scoring; positive screen suggests probable BED.	Validated for BED with good reliability and specificity.	7 questions (~2–3 minutes)	Primary care; obesity medicine; endocrinology; weight-management programs
Eating Disorder Examination Questionnaire (EDE-Q) https://www.corc.uk.net/outcome-measures-guidance/directory-of-outcome-measures/eating-disorder-examination-questionnaire-ede-q/	Self-report tool assessing frequency and severity of eating-disorder behaviors.	Produces subscale and global scores; higher scores indicate greater severity.	Gold-standard symptom severity measure with strong psychometric validity.	28 questions; past 28 days (~10–15 minutes)	Follow-up assessment; behavioral health; specialty eating-disorder care

- **Bariatric surgery** is a covered benefit when medically appropriate and is subject to prior authorization requirements. Refer to Section VII. Utilization Management Program, D. Outpatient Services Requiring Prior Authorization.

18. 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.

19. Non-Emergency Medical Transportation Services (NEMT Services)

NEMT Services are provided for BlueCare and TennCare*Select* members to and from health care appointments. All non-emergency transportation should be scheduled and received prior authorization from Verida, Inc. before a trip is provided. A notice of at least two (2) business days is requested prior to the member's appointment unless a trip is determined urgent. 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:

- 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 provided 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.

- **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/TennCare*Select*.

If BlueCare/TennCare*Select* has PCPs available within 30 miles of the Member's address, and the Member elects or chooses a PCP out of that range, BlueCare/TennCare*Select* may not be responsible for transportation services. Letters 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.*

Health Care Services Greater Than 90 Miles

Transportation that is greater than 90 miles from the member's address for a health care service is not covered.

Exceptions: Transportation that is greater than 90 miles from the member's address to a health care service may be provided 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.
- **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/TennCare*Select*.

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

Requesting NEMT Trips:

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

BlueCare Statewide

Phone 1-855-735-4660

Fax 423-370-1422

TennCare*Select* Statewide

Phone 1-866-473-7565

Fax 423-370-1422

Note: Members can also arrange transportation online at http://member.verida.com/

Verida also offers a Facility/Provider Portal that can be used by facilities and provider offices to schedule transportation on behalf of our members. For additional information on the portal contact Verida at the number below if you are interested in getting access to the portal.

Heath Williams
Facility Manager
423-326-6331
hwilliams@verida.com

Out of state trips or trips for minors without an escort – BlueCare and TennCare*Select* Members and/or their representatives should request NEMT Services by contacting BlueCare Tennessee or TennCare*Select* at the following toll-free numbers, available 8:00 AM – 6:00 PM EST Monday – Friday.

BlueCare Statewide

Phone 1-800-468-9698

TennCare*Select* Statewide

Phone 1-800-263-5479

BlueCare Tennessee and Verida are working together to provide BlueCare and TennCare*Select* Members with access to non-emergency transportation using public transit systems. When a Member or health care Provider calls Verida 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.

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.

Contract Compliance

Verida, Inc. shall comply with clear and measurable service standards of accountability as defined by TennCare and BlueCare Tennessee. When Verida, 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 Verida 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. Verida 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, Verida, 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 Verida, Inc. on an approved Trip Reimbursement Form (Driver Log), through Verida 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 Verida, Inc. for reimbursement, will be returned if not completed accurately and in accordance with the terms of their contract before submitting it to Verida 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) services. NEMT Services are defined below:

Trip Leg- One way transport from a pick-up point to a destination.

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 minimum, these shall be considered urgent transport: Hospital and Crisis Stabilization Unit discharges and same-day appointments with outpatient behavioral health providers. Dialysis as determined as urgent.

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

20. 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.

21. 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.

22. 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.

In Network Providers: Hourly Home Health Nursing, Hourly Home Health Aide and Private Duty Nursing require Prior Authorization. Intermittent services such as: Home Health Nursing Visits, Home Health Aide Visits, Therapies and Social Worker Services, do not require Prior Authorization.

Out of Network Providers: All Home Health services require an authorization.

The home health agency is responsible for ensuring that the prior authorization process is completed within designated time frames.

The following services are Covered when ordered by a treating Physician or other licensed health care Provider practicing within the scope of their license who is treating the Member 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; and
- Audiology 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:

Home Health Aide Care	Home Health Nurse Care
•Extended Visits (S-Code: S9122) Up to 35 hours per week ➢ No more than 8 hours/day ➢ No more than 2 visits/day ➢ HH aide and nurse combined cannot exceed 35 hours per week	•Extended Visits (S-Codes: S9123/S9124) Up to 27 hours per week ➢ No more than 8 hours/day ➢ No more than 1 visit/day ➢ HH nurse and aide care combined cannot exceed 35 hours per week
•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
•Intermittent Visits (G-Code: G0156) Up to 7 hours/28 units per week ➢ Up to 4 units maximum (15 minute increments) per day ➢ 4 units (15 minute increments) may be provided in 2 visits/day	•Intermittent Visits (G-Codes: G0299/G0300) Up to 7 hours/28 units per week ➢ Up to 4 units maximum (15 minute increments) per day ➢ Limit of 1 visit/day
•For example, 4 units per day= ➢ 2 units (30 minutes) in AM on Monday ➢ 2 units (30 minutes) in PM on Monday ➢ 4 units (60 minutes) in one visit Tuesday	•For example, 4 units per day= ➢ No more than 60 minutes on Monday, Wednesday, and Friday for 3 visits per week

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:

Home Health Aide Care	Home Health Nurse Care
•Up to 40 hours per week ➢ No more than 8 hours/day ➢ No more than 2 visits/day ➢ HH aide and nurse combined cannot exceed 40 hours per week	•Up to 30 hours per week ➢ No more than 8 hours/day ➢ No more than 1 visit/day ➢ HH nurse and aide care combined cannot exceed 40 hours per week
•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

Note: Requests for home health nursing and aide services greater than eight (8) hours, and all Private Duty Nursing services for BlueCare and TennCare*Select* Members should be submitted via e-Health Services on the company website, 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, Home Health Nursing, Home Health Aide request form located on BlueCare Tennessee website at Authorizations & Appeals | BlueCare Tennessee.

Effective immediately, Home Health Speech Therapy (ST), Occupational Therapy (OT), and Physical Therapy (PT) will require UM Notification regardless of member's age. Home Health Clinical Social Worker visits will also require notification.

All Providers requesting and providing services and seeking claims payments for BlueCare/TennCare*Select*/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. 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.

1. The following information must be provided when seeking prior authorization for all home health nurse, home health aide, and private duty nursing services:
    a. Name of Physician or other licensed health care Provider practicing within the scope of their license prescribing the service(s)
    b. Specific information regarding the Member's medical condition and any associated disability that creates the need for the requested service(s)
    c. 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).
2. 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:
    a. The home health nurse or home health aide shall not transport the recipient;
    b. 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.

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

3. 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:

   a. 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.

   b. 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.

4. Missed Home Health Aide and Private Duty Nursing Visits.

   a. A "Missed Visit" means a period of one (1) or more hours that a staff member of a home health agency fails to furnish the home health service that a TennCare Member is authorized to receive. Whenever a missed visit occurs, the home health agency must immediately notify BlueCare Tennessee.
   b. It is the responsibility of the home health agency to provide coverage for all shifts/visits and exhaust all coverage possibilities prior to submitting the MCO Universal Home Health Missed Visit Form either via fax to 423-535-1931/1-833-744-7587 or online through Availity to BlueCare Tennessee. 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.

Electronic Visit Verification (EVV)

Effective Jan. 1, 2023, all agencies that provide home health services to patients enrolled in a Medicaid plan must have an electronic visit verification (EVV) system in place for staff use to be in compliance with the 21st Century Cures Act. At a minimum, EVV systems should track the:

- Type of service performed
- Individual receiving services
- Date of service
- Location of service
- Individual providing the service
- Time the service begins and ends

Home health agencies can use the EVV vendor of their choice to capture the required data. The EVV vendor used by the home health agency must be connected to the MCO's aggregator in order to capture the visit information.

For more information or for any questions, please contact your Provider Network Manager. You can also access additional resources about EVV by visiting bluecare.bcbst.com/providers/tools-resources and choose **Resources for Home Health Providers.**

Please note that beginning July 1, 2023, we'll deny claims for home health services if an agency isn't using an electronic visit verification (EVV) system. As a reminder, all home health agencies treating members enrolled in a Medicaid plan must use an EVV system to track that member visits occurred as scheduled.

Please visit the bcbst.com website at https://bluecare.bcbst.com/providers/tools-resources/general/home-health to view all provider home health resources.

23. Prescription Drugs

Prescription drug benefits are administered by OptumRx through the Division of TennCare's Pharmacy Program. Providers are responsible for following the BlueCare/TennCare*Select* preferred drug list (PDL) located at the following site: https://www.optumrx.com/oe_tenncare/landing.

Effective January 1, 2021, CoverKids Pharmacy Benefits Manager is OptumRX. CoverKids formulary is located at the following site: https://www.optumrx.com/oe_coverkids/landing. Additionally, Providers shall coordinate pharmacy prior authorization requests with OptumRX.

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†. See OptumRX billing procedures in Section V. Billing and Reimbursement in this Manual.

†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/content/dam/tn/tenncare/documents/PharmacyProviderManual.pdf

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/.

24. Durable Medical Equipment (DME)

As of March 6, 2026, the DME network transitioned to CareCentrix. Home Infusion Therapy (HIT) and Orthotics and Prosthetics (O&P) services are excluded from this transition. Providers may contact CareCentrix via the Call Center at 833-715-7767.

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 on all Durable Medical Equipment, and Orthotics and Prosthetics (O&P) provided by a DME/O&P Provider costing more than $500 (with some exceptions as noted below).

DME codes and supplies that do require prior authorization (regardless of cost) are listed below:

- Exclusions specified by TennCare (per TennCare Rules)
- Miscellaneous DME codes
- All hospital beds, mattresses, and accessories codes
- Prosthetics and accessories (Mastectomy prosthetic codes don't require authorization due to Tennessee code Ann. § 56-7-2507)
- Wheelchairs and accessories
- All repairs and replacements (except CRT repairs)
- Labor charges

- Incontinence products quantity over 200 (quantities over 800 for (A4335) wipes)
- All enteral and oral formula [does not include Total Parenteral Nutrition (TPN)]
- Equipment rentals (This exception does not include the rental of apnea monitors, bedside commode, humidifiers, phototherapy (Bili-lights), breast pumps, pulse oximeters and nebulizers)
- OON Providers: Requests from providers with an out of network status or pay as par status requires prior authorization.

DME codes and supplies that do not require prior authorization (regardless of cost) are listed below:

- Surgical Codes should be billed with the surgical procedure, if a DME item is used within the procedure prior authorization is not required for DME item. Please refer to the Outpatient (OP) prior authorization list for the surgical procedure
- No authorization is required for Bath/Shower Equipment/Supplies
- No authorization is required for Upper Extremity Orthotics
- No authorization is required for all Diabetic equipment/supplies (including all Continuous Glucose Monitors (CGM) and Insulin pumps)
- No authorization is required for Ankle Foot Orthotics (AFO)
- No authorization is required for compression garments/stockings
- No authorization is required for hearing aids, vision and cochlear implants for under 21 years of age for BlueCare/TennCare*Select* or under 19 years of age for CoverKids (except V2025, V2762, V2781- these require authorization)
- No authorization is required for supplies (examples are wound, trach, foley, ostomy supplies, etc.)
- CRT repairs

Suppliers that provide durable medical equipment (DME) to our members must keep proof of delivery documentation in their files for seven years starting from the date of service. Proof of delivery fulfills contractual obligations (please see 42 CFR Section 424.57(c)(12) for more information). Federal regulations also allow Medicare Administrative Contractors to request information necessary for determining the payment amount due, including proof of delivery verifying the person received their items.

Documentation Requirements

Suppliers can distribute DME prosthetics, orthotics and supplies three ways:

- Delivering the items directly to the beneficiary or their designee
- Using a delivery or shipping service to transport the items
- Sending the items to a nursing facility on behalf of the beneficiary

Once people receive their supplies, they or their designees must sign to accept them. If the signature isn't legible, the supplier or shipping services should print the name of the designee on the delivery slip.

Documentation must also include a date of service – the same date included on the claim. The following dates qualify as the date of service, depending on the delivery method:

- The date the person received the item from the supplier
- The date the shipping label was created (if a shipping service is used)
- The date the package was retrieved for delivery (if a shipping service is used)

For more information about these requirements, please visit https://www.cms.gov/

Complex Rehab Technology (CRT)

For Complex Rehabilitation Technology, all codes/line items to be billed must be provided to pre-review for billable codes and provide coverage determinations for services. For DME to be reviewed as CRT you must complete the CRT DME Authorization Form with the required information. Forms are located on BCBST.com in the provider section. Forms | Providers | BlueCare Tennessee (bcbst.com)

Prior authorization isn't required for repairs of such technology or equipment unless"

- The repairs are covered under a manufacturer's warranty:
- The cost of the repairs exceeds the cost to replace the CRT or manual wheelchair: OR
- The CRT or manual wheelchair in need of repair is subject to replacement because the age of the CRT or manual wheelchair exceeds, or is within one year of the expiration of, the recommended lifespan of the CRT or manual wheelchair.

The Tennessee General Assembly recently passed legislation with new coverage guidelines for the repair of Complex Rehabilitation Technology (CRT), including manual and power wheelchairs. These guidelines take effect July 1, 2024.

Beginning July 1, we'll cover:

- Repairs provided by an authorized CRT equipment supplier.
- At least one preventive maintenance visit per year provided by an authorized CRT equipment supplier. As part of the visit, we'll cover related costs, including parts and services, labor, and the diagnostic and evaluation time required.

A qualified technician employed by the authorized technology supplier must perform the preventive maintenance according to the manufacturer's guidelines and document and maintain a record of the services provided. Our members don't have to schedule a separate visit for preventive maintenance – CRT suppliers can perform preventive maintenance during visits for unrelated services.

Other CRT Coverage Policies

Medical documentation or proof for the continued need for repair or preventive maintenance isn't required for coverage. We'll also reimburse telehealth visits for CRT for dates of service on or after July 1. **Please note**, we may still require documentation of a medical necessity determination for CRT.

For more information about these changes, please review the legislation here.

An electric breast pump can be provided with a Physician order and by completing the information at https://aeroflowbreastpumps.com/qualify-through-insurance

Codes for incontinence supplies and products listed below:

***Note:** Incontinence products only covered for members age 4 years and over if needed for medical condition [See TennCare Rule 1200-13-13-.10(3)(b)17(iii)], except infant Diapers as described in Rule .04, pharmacy program.

***Note:** Quantities >200 require prior authorization submitted for the codes listed below. Beginning 5/1/2024, quantities >800 for wipes (A4335) will require review for medical necessity.

A4335	Incontinence supply; misc.	T4531	Pediatric, small/medium, pull-on
A4335SC	Diaper wipes/disposable washcloth	T4532	Pediatric, large, pull-on
A4554	Disposable underpads, any size	T4533	Youth, brief/diaper
T4521	Adult, small, brief/diaper	T4534	Youth, pull-on
T4522	Adult, medium, brief/diaper	T4535	Liner/shield/guard/pad/undergarment
T4523	Adult, large, brief/diaper	T4536	Pull-on, reusable, any size
T4524	Adult, extra-large, brief/diaper	T4537	Protective underpad, reusable, any size
T4525	Adult, pull-on, small	T4539	Diaper/brief, reusable
T4526	Adult, pull-on, medium	T4540	Protective underpad, reusable, chair size
T4527	Adult, pull-on, large	T4541	Disposable underpad, large
T4528	Adult, pull-on, extra large	T4542	Disposable underpad, small
T4529	Pediatric, small/medium, brief/diaper	T4543	Brief/Diaper, Bariatric
T4530	Pediatric, large, brief/diaper	T4544	Adult sized pull up diapers

"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.)

25. 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.

26. 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 costing more than $500 require prior authorization. BlueCare Tennessee will manage all prosthetic authorization requests (see exceptions under DME).

27. Orthotic Devices

All orthotic devices serviced or supplied by an orthotic Provider costing more than $500 require prior authorization. BlueCare Tennessee will manage all orthotic authorization requests (see exceptions under DME).

28. 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 a cost-effective alternative. All inpatient admissions require prior authorization. (Refer to Utilization Management section in this Manual for authorization requirements.)

29. Chiropractic Services

BlueCare Tennessee covers chiropractic services as medically necessary for all members, regardless of age, beginning January 1, 2022. Coverage includes an initial exam and spinal X-ray, as well as ongoing spinal manipulation.

Important Coverage Reminders

When providing and billing for chiropractic services, please keep these guidelines in mind:

- Chiropractic coverage is limited to an exam, one spinal X-ray and ongoing spinal manipulation only (CPT® codes 98940, 98941, 98942). **Note:** We will only cover one spinal X-ray during the initial exam. Additional X-ray services, or services outside of the spinal manipulation will not be covered.

30. 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.

Notification/prior authorization is not required for the provision of hospice services. As with all services, claims submitted for hospice services are subject to post-payment claims audits to review for appropriate

documentation, medical necessity of days billed, services coded at the appropriate level and/or billed according to recognized utilization standards. Hospice services are a covered benefit in §§1861(dd), 1812(a), and 1814(a)(i) of the Social Security Act, and are only considered by Medicare to be reasonable and necessary if the patient ***meets all of the requirements outlined in 42 CFR 418, subpart B, and as interpreted in the Medicare Benefit Policy Manual, Chapters 9 and 11. Claims*** not meeting these requirements will be recouped.

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.

31. 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.

32. Dental Services

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

Effective 1/1/2023, Dental services are covered for all BlueCare/TennCare*Select* members.

All dental services are provided to Members through one statewide Dental Benefit Manager (DBM). Services are provided as Medically Necessary to treat the oral health needs of these Members. Until Oct. 31, 2025, please call DentaQuest Customer Service at 1-800-294-9650 if you need more information. Effective Nov. 1, 2025, Renaissance will be administering our members' dental benefits. If you need additional information after Nov. 1, please call Renaissance at 1-866-864-2526.

Facility, medical and anesthesia services related to a dental service that are not provided by a dentist or in a dentist's office are covered by BlueCare when the dental service is covered by the dental benefits manager (DBM) or the Tennessee Department of Disability and Aging (DDA).

Adult dental benefits are not applicable to members who have CoverKids. CoverKids children have dental benefits through age 18.

Note: Effective November 1, 2025, Renaissance will be the new Dental Benefits Provider. Customer Service Phone number will be 1-866-864-2526.

33. 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.

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.

Health Care Benefits for Incarcerated TennCare Members

Effective **Jan. 1, 2026**, eligible TennCare members get limited benefits when preparing for release and in the transition period after release from state prisons, local jails, juvenile detention centers and youth correctional facilities.

Eligibility

Individuals must meet these requirements to qualify:

- Be TennCare-eligible
- Under age 21 or up to age 26 if formerly in foster care
- Post-adjudication
- Eligible for release or transitioning after release from incarceration

Covered Benefits

Benefits include a screening and diagnostic visit (physical, dental and behavioral health) and targeted case management 30 days before release and full benefits including targeted case management, dental and pharmacy for 30 days after release.

Participating Providers

To provide well-visits and targeted case management to eligible incarcerated members, providers must:

- Have a National Provider Identifier (NPI) and Tennessee Medicaid ID.
- Complete the Provider Enrollment Steps and satisfy BlueCare Tennessee's credentialing and participation requirements.
- Enroll in the TennCare*Select* provider network.
- Sign a participating provider agreement.
- Comply with any requirements set by the jail or prison where care is provided.
- Submit claims after providing services.

Please email Contracts_Reqs_GM@bcbst.com or call **1-800-924-7141** if you have questions or are interested in providing these services.

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.

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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.

As of 2020, the Episodes of Care program has 48 episodes in performance. Each Wave includes 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 website at https://bluecare.bcbst.com/providers/quality-initiatives/quality-care-initiatives.

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.

Note: Effective 1/1/21, CoverKids will be exempt from the *Tennessee Health Care Innovation Initiative (THCII)*.

A. How to File a BlueCare Tennessee 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.

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/ecomm/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		**Enrollment**	
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:

Protocol	Description
HTTPS Website, https://mftweb.bcbst.com/myfilegateway	The BlueCross BlueShield of Tennessee secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.
SFTP (server mftsftp.bcbst.com)	The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.
FTP/SSL (server mftsftp.bcbst.com)	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.

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.

For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company website, www.wpc-edi.com. Additional companion documents needed for BlueCare Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/ecomm/technical-information.shtml.

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-1500 Physician's Manual	Tennessee Uniform Procedure Coding Manual
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, electronic 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.
- 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 for both Professional and Facility claim forms.

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)

ANSI 837 Loop	Field Description	837P/I Segment
2300	**Attachment Report Type Code** Use the values indicated in the IG to identify the type of attachment.	PWK01
2300	**Attachment Transmission Code** 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.	PWK02
2300	**Identification Code Qualifier** Use code value of AC (Attachment Control Number). This data element is required if PWK02 = FX.	PWK05
2300	**PWK06 Attachment Control Number** This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the "Attachment Fax Sheet".	PWK06

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 Tennessee PCP Physician extender name in Block 31 and supervising BlueCare Tennessee 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 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

  - Form Locator 10 must be a continuous 8-digit number (Correct: January 1, 2004 = 01042004)
  - 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 original BlueCare Tennessee remittance. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

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. (See Vendor Audits for more details.)

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

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.

Exception: Corrected bills submitted by school districts must be received within 60 days from the date of denial or 365 days from the date of services, whichever is later.

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. Electronic and paper corrected claims that don't follow the billing guidelines outlined below will be denied as duplicate submissions. These guidelines also apply when submitting a correction to an Explanation of Benefits (EOB) form. The associated claims should be submitted as described above to prevent claims denial.

The following guidelines are based on National Implementation Guides found at http://www.wpc-edi.com

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 PROCDURE 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 include 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:

- Inpatient administered drugs
- Vaccines

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 milliliters administered. Decimal points are allowed in the event they are needed.
- **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::::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.

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

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.

- 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

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 “Through”

date will be used for determining timely filing. However, in the case of retroactive 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 Member'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 (see Vendor Audits for more details).

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

School Based Services outlined in the IEP or IHP

BlueCare Tennessee Members will not 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 Tennessee 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 Tennessee 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.*

School Districts must submit claims and any required documentation within 365 days of the date of service. Any claims submitted outside of the 365-day timeframe, will be denied for timely filing. Corrected bills must be submitted within sixty (60) days from the date of denial or three hundred and sixty-five (365) days from the date of services, whichever is later.

Provider Submitted Crossover Claim Timely Filing Guidelines

- **Standard Timely Filing**
  - Providers have 365 days from the Date of Service (DOS) **OR**
    180 days from the paid date on the Medicare MSN/DSNP EOB,
    whichever is greater, to submit a claim for cost share reimbursement.
- **If Initial Claim was Submitted Timely but Returned or Rejected**
  - Provider has 60 days from the date of rejection **OR**
    180 days from DOS, whichever is greater, but no more than 240 days total
- **If Initial Claim is Rejected After Timely Filing**

- No additional 60-day extension is granted.
  Provider must still comply with the original timely filing limits.

D. Medicare/BlueCare Tennessee Dual Eligible Members

BlueCare Tennessee 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 Tennessee should only be billed for Medicaid covered services when Medicare has indicated that the service is non-covered and is the Member's liability.

Medicare/Medicaid Dual Eligible Members

Claims filed for dual eligible Members should be filed to Medicare, the applicable Dual Special Needs plan (DSNP) or Medicare Advantage plan (MA) for primary payment. Claims billed to Medicare or a DSNP should crossover to BlueCare/TennCare*Select* for processing of the Medicare/DSNP cost-share amounts.

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 Tennessee 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; 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:

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 02/01/2024, all incontinence products will be provided by Home Care Delivered. 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 Home Care Delivered.
   Note: Incontinence products are not a covered service for CoverKids.

   If the probable existence of TPL for a particular Member 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 Member 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. 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 (Effective 1/1/21, CoverKids will be a part of the Pay and Chase process)

Providers are always encouraged to identify third party liability and bill claims to the primary carrier for covered services. However, in accordance with the contractual agreement between BlueCare Tennessee, and the Division of TennCare, claims submitted to BlueCare Tennessee for the services and conditions listed below will **not** be denied for a primary carrier's EOB. Instead, BlueCare Tennessee will reimburse Providers for the Medically Necessary services and seek to recover payments from any third party coverage that may exist.

- TennCare Kids;
- Preventive pediatric care including Vaccines for Children (VFC) services** for BlueCare and TennCare*Select* Members;
- All services for CoverKids Members under the age of 21 years; and
- All claims covered by absent parent maintained insurance under Part D of Title IV of the Social Security Act.

As required by TennCare guidelines, 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 homeowner'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. Please note that when billing claims secondary to a commercial plan or a Medicare payer, the primary payer's explanation of benefits must be submitted along with the secondary claim and must contain a valid and accurate policy number and the correct Insurance Indicator. The following are appropriate indicators when filling secondary to traditional Medicare. Dual Special Needs Plans and Medicare Advantage plans.

- 16 – Health Maintenance Organization (HMO) Medicare Risk
- MA – Medicare Part A
- MB – Medicare Part B

BlueCare, TennCare*Select*, and CoverKids are always the payers of last resort. When determining appropriate reimbursement for claims where a commercial carrier is the 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 (BCT) allowable amount for the charges, BCT will make no additional reimbursement on the claim.

If the third-party payment is less than BCT's allowed amount, BCT's payment will equal the BCT 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 (including DSNPs or Medicare Advantage plans) is primary is slightly different than the above.

BCT 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.

Where a Member's Medicare or DSNP Part A benefits are exhausted, BCT still requires a copy of the Medicare Parts A and B Explanations of Benefits in order to determine appropriate reimbursement for the Medicare/DSNP non-covered services and will utilize the Part B payment amount to determine the total third-party payment. Reimbursement for the exhausted Part A services listed on the secondary claim will be equal to the BCT allowed amount minus the third-party payment.

Note: When billing for services non-covered by Medicare or a commercial payer, all normal billing guidelines apply including but not limited to, prior authorizations, electronic billing and timely filing.

Medicare/Dual-Special Needs Plans Crossover Process

Effective for dates of service 1/1/24 and after, claims billed to Medicare or a Dual Special Needs Plan (DSNP) will automatically crossover to BlueCare/TennCare*Select* for processing of the Medicare/DSNP copay, coinsurance and deductible (cost-share) amounts in accordance with the pricing methodologies defined by the Division of TennCare for services covered by those entities. Any Medicaid services billed on a crossover claim will not be considered for reimbursement. Those services should continue to be submitted by providers to BCT as secondary claims to be processed according to our existing COB reimbursement guidelines.

Crossover claims can be identified by the following unique claim number prefixes.

- CCX – Indicates that the claim was crossed over by Medicare.
- BBX – Indicates that the claim was crossed over by a DSNP.
- SPX – Indicates that the claim was internally created by BCT to process the cost-share amounts when a claim fails to cross over from Medicare or a DSNP.

Qualified Medicare Beneficiary Only (QMB only) Members

All QMB-only members are assigned to TennCare*Select* by the Division of TennCare for processing of their Medicare/DSNP cost-share amounts. As with above, their claims should cross over from Medicare or a DSNP. Individuals in the QMB-only eligibility category are not eligible for Medicaid benefits and any Medicaid service submitted by a provider will be denied reflecting the members' ineligibility. If a claim does not cross over from Medicare or a DSNP, providers should call our Customer Service Department for assistance.

Please note, dates of service prior to 1/1/24 should continue to be submitted to the Division of TennCare for processing of the Medicare/DSNP copay, coinsurance and deductible amounts, and any remaining Medicaid covered service should continue to be billed to BlueCare/TennCare as secondary claims for processing of those services. Additionally, for any claims billed to Medicare or DSNP that do not automatically crossover, providers should allow 60 days or more from the Medicare or DSNP paid date before submitting a claim to BlueCare/TennCare*Select* for processing of the Medicare/DSNP cost-share amounts. For additional information on the Medicare/DSNP Crossover process, you can find a detailed list of FAQs on the provider News & Manual section of our website.

F. General Billing and Reimbursement Information

In accordance with federal and state requirements, all Providers requesting and providing services and seeking claims payment for BlueCare Tennessee 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.

NOTE: BCT uses the following hierarchy for coding, billing, and reimbursement of claims.

1. Provider's contract
2. BCBST policies and procedures
3. CMS guidelines
4. Coding guidelines from CPT
5. Coding guidelines from coding organizations

1. Current Dental Terminology (CDT), Current Procedural Terminology (CPT®), Health Care Financing Administration Common Procedural Coding System (HCPCS) and International Classification of Diseases (ICD) Coding

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, Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C guidelines (e.g., the DMEPOS Supplier Manual and Revisions, DME MAC Jurisdiction C Fee Schedule, Pricing, Data Analysis and Coding Contractor (PDAC*) Product Classification Lists and Pricing, Data Analysis and Coding Contractor (PDAC*) Coding Bulletins.*

*This document is located on the Palmetto GBA, LLC website at https://www4.palmettogba.com/pdac_dmecs.

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, periodontic, 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 periodontic 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:

Effective Date of Change by the American Dental Association	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1

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:

Effective Date of Change by the American Medical Association	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1
July 1	July 1	July 1	July 1

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.

NOTE: New Billing Requirements for CPT® - Code 81420

Beginning **Dec. 1, 2025**, providers will only be able to bill one unit of CPT® code 81420 (fetal chromosomal aneuploidy genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, including analysis of chromosomes 13, 18, and 21) in a 10-month period. This code is used for one-time testing during pregnancy, so we'll deny claims for multiple units billed for the same patient within a 10-month period.

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.

Medicare and other insurers cover a variety of services, procedures, supplies, and equipment that are not identified by CPT® codes or have specific program or benefit rules. The level II HCPCS codes were established for submitting claims for these items.

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:

Effective Date of Change	Effective Date of Change by BCBST (Date of Service)		
	Addition	Revision	Deletion
January 1	January 1	January 1	January 1
April 1	April 1	April 1	April 1
July 1	July 1	July 1	July 1
October 1	October 1	October 1	October 1

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 Palmetto GBA, LLC website at https://www4.palmettogba.com/pdac_dmecs.

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

Note: It is imperative that providers accurately report the appropriate diagnosis for patient encounters, services, procedures and medications on the claim form. This is also applicable to services, procedures and medications that require a prior authorization. Even though the supporting clinical information is provided when a prior authorization is requested, the supporting diagnosis must be reported on the claim form just as with any other services, procedures and medications that do not require a prior authorization. Claims that do not have supporting diagnosis reported will be subject to review.

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:

Effective Date of Change	Effective Date of Change by BCBST (Date of Service)		
	Addition	**Revision**	**Deletion**
April 1	April 1	April 1	April 1
October 1	October 1	October 1	October 1

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:

Date Reimbursement Data is Published by Source	Date Change will be Applied by BCBST
January 1 to March 31	July 1
April 1 to June 30	October 1
July 1 to September 30	January 1
October 1 to December 31	April 1

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.

- For those procedure codes that fall into bands with a fee source of 2025 CMS Resource Based Relative Value Scale (RBRVS), the established fee will be calculated based on the Relative Value Units (RVUs), conversion factors and Geographic Practice Cost Index (GPCIs) effective Jan.1, 2025. No updates will be made to these fee components, except any new procedure code added after Jan. 1, 2025, will be added as noted above. If the AMA modifies the code description, the underlying use of the code or the components that make up the code, we'll treat the code as a new code in order to remain consistent with recognized coding guidelines.
- Other fee components, which are listed in the Guidelines for RBRVS Reimbursement Method in this manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Update to these components may result in increases or decreases to the established fee at the individual code level.

11. Policy for Codes Priced on an Individual Consideration Basis

Code Sets

- Current Dental Terminology (CDT)

- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- Revenue Codes

Claim Types

- CMS-1500 / ANSI-837P
- CMS-1450 / ANSI-837I
- Paper dental claim forms / ANSI-837D

The maximum allowable for codes priced on individual consideration are based on an individual claim review.

The codes priced by this policy are identified and published on the Provider Fee Schedules with one of these Maximum Allowable Detail Indicators as follows:

- BU: Reimbursement is included in the reimbursement to which procedure or service is incident.
- BU-PO: Reimbursement is included in the reimbursement to which procedure or service is incident when the location of service is the Physician's office.
- BR: By report/individual consideration.
- IC: Maximum allowable will be determined by individual consideration. An operative report may be required.
- IC-DR: Maximum allowable determined by individual consideration. Name of drug, National Drug Code (NDC#), dosage, and number of units is required.
- IC-SM: Maximum allowable determined by individual consideration. Manufacturer name, product name, product number, and quantity are required.
- IC-RP: Maximum allowable determined by individual consideration. Manufacturer/supplier's invoice listing name of patient, the date of service, Acquisition cost for the radiopharmaceutical(s) or contrast material, and number of doses/units is required.
- RP: Manufacturer/supplier's invoice listing name of patient, the date of service, Acquisition cost for the radiopharmaceutical(s) or contrast material, and number of doses/units is required.
- UL: Unlisted service or procedure - Code should only be used for services or procedures not assigned a CPT® or HCPCS code. For consideration of reimbursement, description and/or radiology report and/or laboratory report and/or a manufacturer/suppliers invoice and/or name of drug, NDC#, Dosage, number of units is required.
- UL-SM: Unlisted service or procedure. Manufacturer name, product name, product number, and quantity are required.
- UL-DR: Unlisted service or procedure. Name of drug, National Drug Code (NDC#), dosage, and number of units is required.

The maximum allowable for a code priced on individual consideration may vary by claim based on:

- Supplemental information provided with the claim or related claims.
    - Supplemental information includes, but is not limited to:
        - A description of the procedure or service provided.
        - An operative report for surgical procedures.
        - An anesthesia flow sheet for anesthesia procedures.
        - The name of the drug/immune globulin/vaccine/toxoid/radiopharmaceuticals/contrast material, National Drug Code (NDC), dosage, and number of units provided.
        - The manufacturer's name, product name, product number, and quantity for durable medical equipment, medical supplies, orthotics, and prosthetics.
        - A manufacturer/supplier's invoice listing the name of the patient, date of service, number of units provided, and acquisition cost for radiopharmaceuticals or contrast materials.
        - Documentation of the time and effort necessary to perform procedure or service.
        - Information published by governing coding organizations available at the time the claim is reviewed.
        - Information published by established primary, secondary, or tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy at the time the claim is reviewed.

Codes priced on an individual consideration basis are generally limited to new codes added by the governing coding organizations.

The objective is to establish maximum allowables and/or reimbursement policies for new codes added by the governing coding organizations as quickly as possible when feasible and appropriate.

Establishing maximum allowables and/or reimbursement policies for codes priced on individual consideration is not always feasible or appropriate due to various reasons including, but not limited to:

- Unlisted, miscellaneous, non-specific, or not otherwise classified (NOC) procedures/services.
- Generic codes where different levels of reimbursement are warranted.
- Codes that are not used frequently.
- Delays in publication of guidelines by governing coding organizations.
- Delays in publication of benchmark data by established primary, secondary, or
- Tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy.

When maximum allowables and/or reimbursement policies are developed, they will be implemented based on the greater of the effective date of the code, the effective date of the network, or the effective date of the schedule (e.g., fee schedule, unit schedule) in order to facilitate automated claims adjudication. In the event the reimbursement for a code priced on an individual consideration basis is different than the established maximum allowable and/or reimbursement policy, claims processed during the interim period will not be adjusted by BlueCare Tennessee unless claims are resubmitted by the Provider or adjusted for an unrelated reason (e.g., Member eligibility, Member benefits, medical policy, utilization management, or through routine audit activities).

In some cases, it may be necessary to change pricing for a code that has an established maximum allowable and/or reimbursement policy to individual consideration due to various reasons including, but not limited to:

- Codes revised by governing coding organizations that result in a significant change in reimbursement (e.g., code definition changes from 1 unit = 1 pair to 1 unit = box of 100; code definition changes from 1 unit = box of 100 to 1 unit = 1 pair).
- Codes where there is a conflict between guidelines published by governing coding organizations and information published by established primary, secondary, or tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy.
- Pricing that is frequently overturned as the result of a Level I or Level II appeal.

In some cases, a code may be published externally as individual consideration, but an interim maximum allowable or reimbursement policy is configured on the adjudication system. This typically occurs when an interim maximum allowable or reimbursement policy is applied consistently for all claims for each standard network agreement, non-standard network agreement, and/or claim type. The purpose of configuring the interim maximum allowable or reimbursement policy is to:

- Monitor impact of pricing to BlueCross BlueShield of Tennessee and/or the Provider without having to pend and manually price claims.
- Ensure more accurate and consistent pricing through automated Mechanisms.
- Improve turnaround time for claims processing.

Note: This policy formally documents historical practice for administering codes priced on an individual consideration basis.

Reminder: Counting Minutes for Timed Therapy Codes in 15 Minute Units

This is a reminder that claims submitted for timed codes should be submitted in accordance with CMS coding standards, known as the “8-minute rule” for all lines of business. For a full explanation of this standard, please review CMS Claims Processing Manual: Chapter 5, 20.2(C) “Counting Minutes for Timed Codes in 15 Minute Units”, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf

12. BCT Laboratory Testing Code Reimbursement Policy

This policy applies to reimbursement for BCT Laboratory Testing Services as indicated below and billed on a professional or institutional claim form for all BCT lines of business.

This policy outlines that certain diagnostic laboratory code testing procedures will be reimbursed based on the BCT Laboratory Testing Code Reimbursement policy editing criteria. The allowable for each test is subject to the provider's contracted reimbursement methodology. Please refer to the list of these testing code policies with the code editing criteria policy located under the Code Edit section of the BCBST website at BCBST.com.

13. Sexually Transmitted Infections Testing

For professional providers submitting claims for sexually transmitted infection (STI) testing, there are single STI CPT® codes (87491, 87591, 87661) which are differentiated by the specific causative infectious agent. Separately, there is a comprehensive STI CPT® code (87801), which is for more than one organism tested.

Effective for claims with dates of service on or after October 1, 2025, BCBST will deny claims with two or more single STI testing CPT® codes performed by the same provider on the same date of service and ask provider to refile with the more comprehensive STI CPT® test code.

This policy applies to services billed on a professional claim form – CMS-1500 or electronic equivalent.

14. Telehealth Originating Site Fees and Billing Guidelines

Effective October 1, 2024, we will only cover the codes listed on the Telehealth Approved Code list. The list can be found on the Manuals, Policies and Guidelines page of bluecare.bcbst.com/providers. Additionally, we're reducing the rates for audio only telehealth services by 15%. Audio only CPT® codes 98008 - 98015, 98966, 98967, and 98968 will be used to identify audio only services that are eligible for the rate reduction.

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

During the pandemic, we greatly expanded our telehealth coverage so providers could continue to provide quality care to our members. This is an ongoing process, and we'll share more information as it becomes available.

Effective 6/1/22, BlueCare Tennessee introduced code edits that ensured only those services that can be performed via Telehealth will be reimbursed. Services that physically cannot be performed via telehealth (e.g., blood draws, surgeries, etc.) will be denied.

Telehealth service modifiers for informational purposes include **GT, 93**, **95, G0, GQ FQ, and FR** but these claims must be billed with the correct place of services **(POS) 10**: Telehealth Provided in Patient's Home or **POS 02**: Telehealth Provider Other than in Patient's Home to ensure appropriate reimbursement. Exceptions to the POS requirement are school-based services and Rural Health Centers (RHC)/Federally Qualified Health Center (FQHC) claims. Telehealth coding for school-based services requires the use of POS 03 and the appropriate modifier or audio only CPT® code. Telehealth coding for RHC/FQHC require the use of POS codes 50 or 72 with the appropriate telehealth modifier or audio only CPT® codes.

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 all appropriate Provider type claims.

If CMS designates a replacement code for Q3014 or updates the fee for Q3014 or its replacement code, BCT will utilize the new code reimbursement to replace the current flat fee.

While 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), under these circumstances, it is not appropriate to bill code Q3014.

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. The GT and 95 modifiers will no longer be required.

Note: 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.

15. Non-Standard Billing Requirement

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.

16. 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 submit a Reconsideration by using the appeal process outlined in Section XII. Provider Agreement, A. Reconsideration., 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, 0452, or 0459 (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 $8.20 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.)

Note: *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.)*

Screening Fee

(Applies 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, 0452, or 0459) 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, 0452, or 0459)
- 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, 0452, or 0459) 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, 0452, or 0459) 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, 0452, or 0459) 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, 0452, or 0459) 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 and will fully compensate Institution for all services and supplies provided in association with an outpatient procedure, including, but not limited to, pre-admission testing provided up to three (3) days prior to surgery at the same facility or an Affiliate, nursing services, ancillary services, medications, and six (6) hours of Observation Services.

- **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 Tennessee emergency diagnosis code listings can be accessed on the Provider page of the company website at: https://bluecare.bcbst.com/forms/Provider Forms/BlueCare_Medical_Emergency_List.pdf.

Emergency Services and Non-Emergency Services Furnished in an Emergency Room – Professional Fees

All emergency-related services furnished by healthcare professionals in an emergency room must be filed on a CMS-1500 claim form with:

- Place of Service Code 23, and
- Appropriate level of care CPT® code (e.g., 99281-99285 or 99291-99292)

When adjudicating claims, emergency benefits are determined and applied based on (1) the primary (diagnosis code A) and secondary (diagnosis code B) submitted in Block 21 of the CMS-1500 professional claim form, and (2) any medical records submitted with the claim.

Professional fees for non-emergency services furnished in an emergency room will be paid $50 per claim, unless the professional's contract provides for payment at a lesser amount. Services filed with the professional fee are not paid separately.

The BlueCare Tennessee emergency diagnosis code listings can be accessed on the Provider page of the company website, http://bluecare.bcbst.com.

17. Durable Medical Equipment, Prosthetics, Orthotics, and Medical Supplies (DMEPOS)

(Applies to CoverKids effective 1/1/21)

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>.

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.

Note: Durable Medical Equipment Reimbursement Methodology applies to BCT contracts only.

18. Division of TennCare Budget Memo Guidelines

(Does Not Apply to CoverKids Unless Otherwise Indicated)

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

- **Several changes to Allergy Immunotherapy and Injection Guidelines took effect July 1, 2019**. Please see below for a summary of notable changes that apply to your **BlueCare, TennCare*Select***, **and CoverKids contracts**:

  CPT® code 95165 – Preparation and Provision of Antigen for Allergen Immunotherapy

  - We follow the Centers for Medicare & Medicaid Services guidelines for one dose/unit of antigen as 1 cc aliquot. Members can receive 150 doses/units per calendar year without a prior authorization. You must have a prior authorization from us to bill more than 150 units using 95165.
  - We can reimburse up to a three (3)-month supply (approximately 37 doses/units) at one time, so billing the full annual quantity is not allowed.

1. CPT® codes 95115 and 95117 – Allergy Injections

- Please report ICD-10 codes on the claim(s) to support the injection code billed.

  - For 95115 (single injection), the claim should include at least one allergy-related diagnosis code.
  - For 95117 (multiple injections), the claim should include two or more allergy-related diagnosis codes.

2. Home Administration

Evidence-based best practice **guidelines** don't support giving patients a self-injectable allergy serum they can use at home. Exceptions should be made on a case-by-case basis. If an exception is made, please discuss the anaphylactic risks associated with self-injection and make sure your patient can safely administer the serum before leaving your office. The patient's medical record should also include an informed consent that's signed by the patient and caregiver(s).

When filing claims for at-home immunotherapy serum administration, bill Modifier 32 with CPT® code 95165.

DME Maximum Fee Schedule (Applies to CoverKids effective 1/1/21)

- 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.

Notes: In addition to this maximum allowable set for Provider rates on the DMEPOS fee schedule, the Division of TennCare has requested a maximum allowable be placed on implant codes L8509 and L8614 for facilities.

DME Maximum Fee Schedule: Application Clarification – Surgical Implants shall be exempt from this requirement.

- **Cesarean and Vaginal Delivery Reimbursement (See Budget Memo Attachment C):** (Applies to CoverKids effective 1/1/21)

Cesarean and Vaginal Delivery Reimbursement (see Attachment C for Crosswalk)			
SFY 2012	**SFY 2013**	**SFY 2014**	**SFY 2015 - Forward**
Effective July 1, 2011	**Effective July 1, 2012**	**Effective July 1, 2013**	**Effective July 1, 2014**
Cesarean and vaginal deliveries will be reimbursed at the same rate effective July 1, 2011. MCOs are directed to increase their	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. MCOs are directed	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for corresponding C-Section deliveries. **MCOs are**	Cesarean and vaginal deliveries are reimbursed at the same rate. MCOs pay the current vaginal delivery rate for

Cesarean and Vaginal Delivery Reimbursement (see Attachment C for Crosswalk)			
vaginal delivery rates by 17%. Additionally, MCOs are to pay the vaginal delivery rate for corresponding C-Section deliveries.	to decrease their vaginal and corresponding C-Section delivery rate by 7% points effective July 1, 2012. This should result in an effective 10% increase from the rates paid before July 1, 2011.	**directed to decrease their vaginal and corresponding C-Section delivery rate by 5% points effective July 1, 2013**. This should result in an effective 5% increase from the rates paid before July 1, 2011.	corresponding C-Section deliveries. Payment should result in an effective 5% increase from the rates paid before July 1, 2011.

- **DME/Back Brace Reimbursement (Applies to CoverKids effective 1/1/21)**

BACK BRACE REIMBURSEMENT		
Effective July 1, 2013		**1% Reduction Effective July 1, 2014**
HCPC Code	Maximum allowed Amount	Maximum allowed Amount
L0637	$ 379.86	$ 376.06
L0631	$ 332.31	$ 328.99
L0627	$ 133.06	$ 131.73

- **Implementation of Medicare standards for coverage of TENS and CLBP (Applies to Cover Kids)**
- **Diapers**
  - Quantities over 200 per month require Prior Authorization.
- **MRI (Applies to CoverKids effective 1/1/21)**
  - 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 Point Injections
    - Limit of four per muscle group in any period of six consecutive months.
  - Epidural Steroid Injections
    - Limit of three in any period of six consecutive months
  - 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).

- Effective 10/6/21, Presumptive Urine Drug Tests using instrument chemistry analyzers are limited to twelve (12) per calendar year. (See Attachment B).

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

➢ **Assay Drug Testing (See Budget Memo Attachment H)**

- Effective 10/1/15, Limit benefit frequency to two (2) services per year (each).
- Effective 10/6/21, Assay Drug Testing: Any combination of confirmatory drug tests represented by G0480, G0481, G0482, G0483 will be limited to twelve (12) per member per calendar year (See Attachment C).

➢ **Therapy Code List (See Budget Memo Attachment I) (Applies to Cover Kids)**

- Effective July 1, 2015, Therapy Codes included in Attachment I shall be reimbursed at the lesser of **1)** the MCOs current reimbursement amount for therapy codes, or **2)** the current published CMS Medicare reimbursement amount.

➢ **E&M/Therapy Same Day (Applies to Cover Kids)**

- 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 (Applies to Cover Kids)**

The initial immunotherapy allergen treatment supply claim should be billed with a – **U1** 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 (Applies to CoverKids)**

- 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 – (Applies to Cover Kids)**

Effective July 1, 2017 (See Budget Reduction Memo Attachments B, D, E & F for applicable codes).

NOTE: Effective April 1, 2023, TennCare MCOs must cover stand-alone vaccine counseling for all vaccines for TennCare members and CoverKids members of all ages. The applicable codes for these services are to be used when providing stand-alone counseling for COVID-19 and non-COVID-19 vaccines whether provided in-person or provided via telehealth (including televisual or audio-only). Reimbursement of stand-alone vaccine counseling for TennCare and CoverKids members of all ages will remain in effect on a permanent basis.

19. Claim Billing Requirements for 340B Drug Pricing Providers

The Division of TennCare has announced billing requirements for providers who are registered on the Medicaid Exclusion File and participate in the federal 340B Drug Pricing Program. The modifier requirement will be determined by the presence of an NDC. While we encourage you to begin using the appropriate modifiers effective May 1, 2021, we won't begin disallowing drugs administered in an office/outpatient setting until Dec. 1, 2021. Professional and facility claims with a date of service on or after Dec. 1 for drugs administered in an office/outpatient setting will need to include one of these modifiers:

- JG – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members

  - JG modifier will no longer be effective for 340B Pricing for dates of service January 1, 2025 and after. TB modifier should be utilized in place of JG after 1/1/25 dates of service.

- TB – Drug or biological acquired with the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes)
- UD – Drug or biological acquired with the 340B drug pricing program discount
- UC – Drug or biological acquired without the 340B drug pricing program discount

Effective Dec. 1, 2021, if a drug service is disallowed because a modifier isn't included on each applicable claim line, the line level denial will show:

- Reason code 16 – Claim/Service lacks information or has submission/billing error(s).
- Remark code N822 – Missing procedure modifier(s).

Please note that claims paid on a case rate or bundled payment are excluded from the modifier requirement. There will be no changes to the current reimbursement for drugs administered on an office/outpatient basis through the 340B Drug Pricing Program. If a claim is submitted without a valid NDC number on the drug line item, the entire claim will reject on the front end and will be sent back for correction.

Check Your Medicaid Exclusion File Participation

The Medicaid Exclusion File is maintained by the Health Resources and Services Administration (HRSA), and you can view the file and check your participation here: 340bopais.hrsa.gov/MedicaidExclusionFiles. Please contact the HRSA directly to update your participation status.

20. Real Time Claim Adjudication

Real Time Claim Estimation/Adjudication (RTCA) provides a secure online environment to create estimates to confirm reimbursement amounts as well as identify member liability at the point of care. You may also submit claims for Tennessee Members through the application.

You will not be able to generate an estimate of member liability nor submit a claim for the following circumstances:

- If the Tennessee Member has other insurance.
- BlueCard (out-of-state Members).
- Inpatient Facility Claims.
- Dental Claims.

Accessing the application is easy. Simply log into Availity® and go to the BCBST Payer Spaces page. Then click on the Real Time Claim Adjudication application tile.

Note: You can also access this application while verifying Member Eligibility & Benefits. Simply click the "Patient Cost Estimator" tab from within the Members benefit screen.

21. Cell Gene Therapy Drugs for Sickle Cell Disease – Casgevy and Lyfgenia

Specialty Pharmacy Billing of Casgevy or Lyfgenia

Claim Type: CMS-1500

Prior authorization is required for these drugs. See the link below for a listing of drugs that require prior authorization and instructions on how to submit the authorization requests:

https://bluecare.bcbst.com/forms/Provider%20Forms/BlueCare-Specialty-Pharmacy-List.pdf

CASGEVY Suspension: J3392 for NDC 51167-0290-09 (code effective 01/01/2025)

LYFGENIA Suspension: J3394 for NDC 73554-1111-01 (code effective 07/01/2024)

Place of Service: 21 Inpatient

Required Modifier: UC - Drug or biological acquired without the 340B drug pricing program discount.

An invoice is required to determine the Actual Acquisition Cost. The invoice should include all rebates and discounts. The invoice can be submitted through the PWK process that is outlined in this section of the BCT Provider administration manual.

Facility Billing of Casgevy or Lyfgenia

Claim Type: CMS-1450

Prior authorization is required for the inpatient stay. Please see the BlueCare Provider Administration Manual (link listed below) for instructions on how to request the prior authorization.

https://www.bcbst.com/providers/manuals/BCT_PAM.pdf?_gl=1*10nm90w*_gcl_au*MTIwMTU0NDc5OC4xNzQ4OTUwMDUy

Revenue Code: 0636

CASGEVY Suspension: J3392 for NDC 51167-0290-09 (code effective 01/01/2025)

LYFGENIA Suspension: J3394 for NDC 73554-1111-01 (code effective 07/01/2024)

Required Modifier: UC - Drug or biological acquired without the 340B drug pricing program discount.

An invoice is required to determine the Actual Acquisition Cost. The invoice should include all rebates and discounts. The invoice can be submitted through the PWK process that is outlined in the provider administration manual under the Billing and Reimbursement section.

If the drug is being supplied through the specialty pharmacy the facility must bill the drug on the facility claim with the appropriate revenue, procedure, and NDC codes with a zero charged amount to trigger the correct facility payment.

22. Bioengineered Skin and Soft Tissue Substitutes

Description: bioengineered skin and soft issue substitutes may be derived from human tissue (autologous or allogeneic), nonhuman tissue (xenographic), synthetic materials, or a composite of these materials. Bioengineered skin and soft tissue substitutes are being evaluated for a variety of conditions, including breast reconstruction and to facilitate healing of lower-extremity ulcers and severe burns. The gold standard for surgical wound repair is to use a skin graft harvested from the individual's own skin (autograft). However, autologous tissue grafting is an invasive and painful procedure, and the extent of damaged skin can be too large to be covered by an autologous graft alone.

BlueCare does not consider skin substitutes as implants.

Payment is included under the Outpatient Surgical Fee (OSF) payment; skin substitutes are not reimbursed separately.

Please refer to the Medical Policy Manual for more details on Bioengineered Skin and Soft Tissue Substitutes.

Prior Authorization

Prior authorization is required for all products if the procedure is performed inpatient and may be required if procedure is performed outpatient. Please Note: Authorization isn't a confirmation of coverage or benefits.

Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions, and the member's eligibility at the time services are rendered.

CPT/HCPCS Codes

Providers should report all services using the most up-to-date procedure, and diagnosis codes, including modifiers where applicable. Please Note, Revenue codes 0278/0636 are valid for this service, depending on the procedure codes billed.

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:

Balance this Page
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1. Sample Copy CMS-1500 (02/12) version claim form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

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

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

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

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

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

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

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

2. CMS-1500 (02/12) Claim Form Block Descriptions:

Block 1	Type of Plan
Block 1a	Insured's ID Number (include three-letter alpha prefix)
Block 2	Patient's Name
Block 3	Patient's Date of Birth
Block 4	Insured's Name
Block 5	Patient's Address and Telephone Number
Block 6	Patient's Relationship to Insured
Block 7	Insured's Address
Block 8	Reserved for NUCC Use
Block 9	Other Insured's Name
Block 9a	Other Insured's Policy or Group Number
Block 9b	Reserved for NUCC Use
Block 9c	Reserved for NUCC Use
Block 10abc	Is Patient's Condition Related To
Block 10d	Claim Codes
Block 11	Insured's Policy Group or FECA Number
Block 11a	Insured's Date of Birth
Block 11b	Other Claim ID
Block 11c	Insurance Plan Name or Program Name
Block 11d	Is There Another Health Benefit Plan
Block 12	Patient's or Authorized Person's Signature (Information Release/Government Assignment)
Block 13	Insured's or Authorized Person's Signature (Payment Authorization)
Block 14	Date of Current Illness, Injury, or Pregnancy (LMP)
Block 15	Other Date
Block 16	Dates Patient Unable to Work in Current Occupation
Block 17	Name of Referring Provider or Other Source
Block 17a	ID Number of Referring Provider or Other Source
Block 17b	NPI (National Provider Identifier) of Referring Provider
Block 18	Hospitalization Dates Related to Current Services
Block 19	Additional Claim Information
Block 20	Outside Lab?
Block 21A-L	Diagnosis or Nature of Illness or Injury and ICD Ind
Block 22	Resubmission Code/Original Reference Number
Block 23	Prior Authorization Number (If Applicable)
Block 24A	Dates of Service
Block 24B	Place of Service

Block 24C	EMG (if emergency indicator required, enter “Y” for yes; leave blank if No)
Block 24D	CPT® or HCPCS code, modifiers
Block 24E	Diagnosis Pointer
Block 24F	Charges
Block 24G	Days or Units
Block 24H	EPSDT/Family Plan (TennCare Kids)
Block 24I	ID Qualifier
Block 24J	Rendering Provider ID Number
Block 25	Federal Tax ID Number or SSN
Block 26	Patient’s Account Number
Block 27	Accept Assignment
Block 28	Total Charge
Block 29	Amount Paid
Block 30	Reserved for NUCC Use
Block 31	Signature of Physician or Supplier
Block 32	Service Facility Location Information (address where service provided)
Block 32a	NPI (National Provider Identifier) of Service Facility
Block 32b	Non-NPI ID Number (unique identifier of the facility)
Block 33	Billing Provider Info and Telephone Number
Block 33a	NPI (National Provider Identifier) of Billing Provider in Block 33)
Block 33b	Non-NPI Number (unique identifier number of professional)

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
    - 2. Manual typewriter standard of Sinclair and Valentine J6983
- 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.
- 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.

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)

INK

Standard is Sinclair and Valentine J6983
Same ink front and back of form
Multi-part forms must have same ink on all copies

MARGIN

Top to typewriter alignment bar is 34mm
Right to left margin is 9mm

ASKEWITY

No greater than .15mm in 100mm
X and Y OFFSET for MARGINS must not vary by more than + or - 0.010 inches from page to page (x= horizontal distance form left margin to print, y= vertical distance from top to print).
NO MODIFICATIONS may be made to the CMS-1500 without the prior approval of the Centers for Medicare and Medicaid Services.

3. Form Contents and Description

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

BLOCK 1 - TYPE OF PLAN

1.MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ (Medicare #)	☐(Medicaid #)	☐(Sponsor's (SSN)	☐ (VA File #)	☐ (SSN or ID)	☐ (SSN)	☐(ID)

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 Members 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

3. PATIENT'S BIRTH DATE			
MM	DD	YY	SEX M ☐ F ☐

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)

5.PATIENT'S ADDRESS (No., Street)	
CITY	STATE
ZIP CODE	TELEPHONE

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
Self ☐ Spouse ☐ Child ☐ Other ☐

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 Member 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? PLACE (State)

YES ☐ NO ☐

c. OTHER ACCIDENT?

YES ☐ NO ☐

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

10d. CLAIM CODES (Designated by NUCC)

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

11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. INSURED'S DATE OF BIRTH			
MM	DD	YY	SEX
			M ☐ F ☐
b. OTHER CLAIM ID (Designated by NUCC)			
c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
YES ☐ NO ☐ If yes, complete items 9, 9a. and 9d			

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."

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						
MM	DD	YY		MM	DD	YY
FROM			TO			

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

17.NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.		
	17b.	NPI	

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. Please refer to Provider Categories/Billing and Supervision Requirements for the member co-pay information.

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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

20. OUTSIDE LAB? $ CHARGES
☐ YES ☐ NO

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

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind								
A.		B.		C.		D.		
E.		F.		G.		H.		
I.		J.		K.		L.		

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 ZZAvastin

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7 Begin 1245 End 1415														1B	12345678901
10	01	05	10	01	05	22		00770	P2	134	875 00	90	N	NPI	0123456789

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7 Begin 1245 End 1415 Time 90 minutes														1B	12345678901
10	01	05	10	01	05	22		00770	P2	134	875 00	6	N	NPI	0123456789

Example 3: Unspecified Code

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker														1B	12345678901
10	01	05	10	01	05	12		E1399		12	165 00	1	N	NPI	0123456789

Example 4: NDC Code

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N450242006001 ME1.25 ZZ Avastin														1B	12345678901
10	01	05	10	01	05	11		J1563		13	500 00	20	N	NPI	0123456789

BLOCK 24A. – 24E. —DATE(S) OF SERVICE, PLACE OF SERVICE, EMG, PROCEDURES, SERVICES OR SUPPLIES, DIAGNOSIS POINTER

24 A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES	E. DIAGNOSIS POINTER

BLOCK 24F. – 24J. - CHARGES, DAYS OR UNITS, EPSDT, ID QUALIFIER, AND RENDERING PROVIDER ID NUMBER

	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. Rendering Provider Id. #
1				**NPI**	
2				**NPI**	
3				**NPI**	
4				**NPI**	
5				**NPI**	
6				**NPI**	

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.

BLOCK 24B — PLACE OF SERVICE

CODE	DESCRIPTION
01	pharmacy
02	telehealth, provided other than in patient’s home
03	school
04	homeless shelter
05	indian health service; free-standing facility
06	indian health service; provider-based facility
07	tribal 638; free-standing facility
08	tribal 638; provider-based facility
09	prison/correctional facility

10	telehealth, provided in patient's home
11	office
12	home
13	assisted living facility
14	group home
15	mobile unit
16	temporary lodging
17	walk-in retail health clinic
18	place of employment/worksite
19	off-campus outpatient hospital
20	urgent care facility (distinct from hospital ER/office/clinic)
21	inpatient hospital (non-psychiatric)
22	on-campus outpatient hospital
23	emergency room, hospital
24	ambulatory surgical center
25	birthing center
26	military treatment facility
27	outreach site/street
28-30	unassigned
31	skilled nursing facility
32	nursing facility
33	custodial care facility
34	hospice
35-40	unassigned
41	ambulance, land
42	ambulance, air or water
43-48	unassigned
49	independent clinic
50	federally qualified health center
51	inpatient, psychiatric facility
52	psychiatric facility, partial hospitalization
53	community mental health center
54	intermediate care facility, individuals with intellectual disabilities
55	residential substance abuse facility
56	psychiatric residential treatment center
57	non-residential substance abuse treatment facility
58	non-residential opioid treatment facility
59	unassigned
60	mass immunization center
61	comprehensive inpatient rehabilitation facility
62	comprehensive outpatient rehabilitation facility
63-64	unassigned
65	end stage renal disease treatment facility
66-70	unassigned
71	state or local public health clinic
72	rural health clinic
73-80	unassigned
81	independent laboratory
82-98	unassigned
99	other, place of service

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 20. 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.

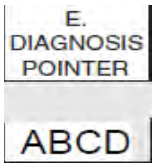
BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES

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 #

Description The individual rendering the service is reported in 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 Provider 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.

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.

- Refer to Provider Categories/Billing and Supervision Requirements for the member co-pay information.

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

25. FEDERAL TAX I.D. NUMBER	SSN	EIN
	☐	☐

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

26.	PATIENT'S ACCOUNT NO

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?

27. ACCEPT ASSIGNMENT?
(For govt. claims, see back)
YES ☐ NO ☐

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	
$	00

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	
$	00

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

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 PRACTITIONER 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.)

BLOCK 32 — SERVICE FACILITY LOCATION INFORMATION

32. SERVICE FACILITY LOCATION INFORMATION	
a. NPI	b.

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 INFOR & PH #

33. BILLING PROVIDER INFO & PH # ( )	
a. NPI	b.

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;
- 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, certified registered nurse anesthetist (CRNA) or Anesthesiology Assistant (CAA) 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, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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:

Modifier	Description
AA	Anesthesia service performed personally by anesthesiologist
AD	Medical supervision by a physician: more than 4 concurrent procedures
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
QX	CRNA or CAA service: with medical direction by a physician
QY	Anesthesiologist medically directs one CRNA
QZ	CRNA service: without medical direction by a physician **(Refer to payment guidelines for this modifier found below in sub section of this reimbursement policy)**

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:

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

(Refer to payment guidelines for these physical status modifiers eff. 10/1/25 found below in sub section of this reimbursement policy).

Paper Claim Form - Block 24G (Days or Units)

Anesthesia time begins when the anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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 24 D (CPT®/HCPCS)

Qualifying circumstances for anesthesia may be billed with the following CPT® codes as applicable:

Code	Description
99100	Anesthesia for patient of extreme age, under one year and over seventy
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency condition

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.

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, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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), or Certified Anesthesiology Assistant (CAA) are based on the lesser of covered charges or the following formula:

Maximum Allowable = **(Basic Value + Time Unit + Physical Status Unit Value) x**

Conversion Factor x 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, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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.

Effective 7/1/2021:

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 nearest tenth (i.e., 1.11 units will be rounded to 1.2 units, 1.41 units will be rounded to 1.5 units, 1.51 units will be rounded to 1.6 units, 1.61 units will be rounded to 1.7 units, 1.91 units will be rounded to 2 units). **Anesthesia time does not apply to Daily Hospital Management Services.**

Physical Status Unit Values

Additional base units for physical status will be allowed as follows:

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

(Refer to payment guidelines for these physical status modifiers eff. 10/1/25 found below in sub section of this reimbursement policy).

Time Units, Conversion Factors and Percentages

Conversion Factors and Percentages follow:

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

Note: Effective January 1, 2026, Modifier QX will apply to Certified Anesthesiology Assistant (CAA) services, same as CRNA.

Medical Supervision of Anesthesia Services

Reimbursement for medical supervision of anesthesia services, (modifier AD), will be limited to three (3) Basic Values, one (1) unit of time, physical status modifier units, when applicable, and 100 percent of the conversion factor for the anesthesiologist.

NOTES for QZ and Physical Status Modifiers Effective October 1, 2025:

1. Anesthesia Services provided by a Certified Registered Nurse Anesthetist (CRNA) without medical direction by a physician should be filed with a QZ modifier appended to the claim. In

these circumstances, the reimbursement will equal 85% of the appropriate fee schedule for all lines on the claim.

2. Consistent with CMS payment policies, physical status modifiers will not be utilized for payment of any anesthesia services. Specifically, BCBST will not provide additional reimbursement for anesthesia services based on the use of physical status modifiers P3 (ASA III), P4 (ASA IV), and P5 (ASA V).
3. Reimbursement for medical supervision of anesthesia services (Modifier AD), will be limited to three basic values, one unit of time, and 100% of the conversion factor for the anesthesiologist.

   Maximum allowable amount for administration of anesthesia performed by an anesthesiologist or nurse anesthetist are based on the lesser of total covered charges or the following formula unless otherwise stated in provider's contract:

Maximum Allowable =	(Basic Value + Time Unit) x Conversion Factor x Percentage

➢ Qualifying Circumstances for Anesthesia

Maximum allowable for qualifying circumstances for anesthesia performed by an anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) are based on the lesser of Covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

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

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

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, Certified Registered Nurse Anesthetist (CRNA), or Certified Anesthesiology Assistant (CAA) 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:

Code	Description	Unit Value	Conversion Factor
01996	Daily Management of epidural or subarachnoid drug administration	3	Refer to contract

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, two CRNA's, two CAA's) for the same episode must be submitted on a single claim, under one NPI, with the date of delivery as the date of service. Separate claims for the multiple providers will result in denial for the add-on code.

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.

Note: Billing Update for Early Elective Deliveries

Beginning Jan. 1, 2021, BlueCare Tennessee providers will need to bill a Z3A diagnosis code to show the gestational age when billing one of the following CPT® codes:

59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, and 59622.

BlueCare Tennessee providers are required to submit Category II codes (0500F, 0501F, 0502F) either on the same claim as the Global OB charge or on a claim submitted prior to the Global OB charge. These codes are only necessary if the Global OB charge is being submitted or is expected to be submitted. Failure to include one of the required Category II codes on the same claim or on a preceding claim will result in denial of the Global OB charge.

Note: Billing Update to Receive Quality Payments

Beginning January 1, 2022, the following coding changes will take effect.

According to ACOG, every mother should be screened at least once for depression and anxiety during the perinatal period, using a standardized validated tool. These changes to coding for quality payments support efforts to encourage perinatal mental health screening and provide increased incentive opportunities for providers.

The following applies for all deliveries (liveborn or non-liveborn), and all risk categories. The length of the postpartum period will be defined as 84 days.

Maternity Care Management Notification form - The OB or PCP providing prenatal care should submit this form within 30 days of the Member's first appointment. For further details about the form and its submission, please see section IX. OB Services.

Through our Maternity Care Program, our network obstetric providers can earn payments on top of regular reimbursements for maternity care.

- 0500F should be billed with one of these CPT codes: 99202-99205, 99211-99215. The maternity care management form is required to be submitted within 30 days from the first prenatal visit for the incentive to be paid.
- 0503F should be billed with CPT code 59430 – Postpartum visit for uncomplicated, routine care. The postpartum visit must be performed within 7 to 84 days of the delivery date for the incentive to be paid.
- 96160 – Mental Health Screening with Validated Tool - should be billed with a TH modifier.

Effective April 1, 2025:

- Providers are asked to submit charges for prenatal or postpartum visit Category II codes 0500F and 0503F with the actual incentive reimbursement amounts. Additional charges may be submitted based on the provider's contract.
- Additional requirements, such as The Date of Last Menstrual Period, are not required elements in the claim for reimbursement.
- The Maternity Care Notification Form must still be submitted within 30 days of submission of the claim.
- The Delivery Date is not a required element in the claim for reimbursement.
- Claims for the postpartum incentive may be submitted and reimbursed twice during the postpartum period (defined as within 84 days or 7-84 days after delivery.

Please refer to the BlueCare website for more details at the following link: Healthymom | Providers | BlueCare Tennessee (bcbst.com)

Note: Effective June 1, 2023, your patients with BlueCare℠ , TennCare*Select* or CoverKids coverage have lactation consultant benefits. These benefits include medically appropriate lactation consultant services from in-network providers during pregnancy and the extended postpartum period. Parents can receive services through telehealth or in-person in a one-on-one or small group setting. There's no limit on the number of visits allowed, but we may request additional information after 15 units are billed. Services should be billed as indicated below:

CPT Code	Description
98960 U8	Single individual per 30 minutes
98961 U8	2-4 patients per 30 minutes
98962 U8	5-8 patients per 30 minutes

Who Can Provide Lactation Services?

- Physicians, nurse practitioners, physician assistants or certified nurse midwives for whom lactation counseling, education or consultation is within their scope of practice
- International Board-Certified Lactation Consultants/Registered Lactation Counselors (IBCLCs/RLCs) with a Medicaid ID in network with a TennCare MCO
- Certified Lactation Specialists (CLSs), Certified Breastfeeding Specialists (CBSs), Certified Lactation Counselors (CLCs) and Certified Lactation Educators (CLEs)
    - Services provided by a CLS, CBS, CLC, and CLE must be supervised and billed by a contacted, in-network provider
- CLSs, CBSs, CLCs, and CLEs can provide direct services under the supervision of:
    - Physicians (MDs/Dos)
    - Physician Assistants (PAs)
    - Nurse Practitioners (NPs)
    - Certified Nurse Midwives (CNMs)
    - International Board-Certified Lactation Consultants (IBCLCs) with medical licensure

Note: The following health care practitioners are not independently credentialed or contracted by BCBST and therefore are not eligible to bill directly for services: CLS, CBS, CLC, and CLE. Services provided by these practitioners must be billed under the supervising provider, and the supervising provider must be listed in Block 24J ("practitioner rendering the service") on the claim. General education and counseling may be delivered by a CLS, CBS, CLC, or CLE within the scope of their licensure. When a higher level of clinical care is required, referrals should be made to an IBCLC or an appropriate medical provider.

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.

Note: Reimbursement for CPT® code 99050 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 physician's office (place of service 11).

Also, reimbursement for CPT® code 99078 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. NCCI edits may still occur for both of these codes.

Code	Effective Date	Exception
96040	1/1/2007	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.
98961 98962	1/1/2006	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.

Code	Effective Date	Exception
99050	1/1/2000	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.
99078	1/1/2000	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.
99100 99116 99135 99140	1/1/2000	Reimbursement is considered bundled with the service to which it is incident with the exception of when the service is performed by an anesthesiologist, CRNA, or CAA related to anesthesia administration.
96041	1/1/2025	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.

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.

The following services will no longer require prior authorization as of Oct. 1, 2020:

- Electromyograph (EMG)
- Nerve Conduction Studies (NCS)*

*In order to receive payment for NCS, the service must be performed/billed with an EMG.

9. Multiple Procedure Payment Policy Rule (MPPR) for Radiology

(Effective for claims with dates of service on and after October 1, 2025)

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the technical component (Modifier TC) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for the technical component of the second and each subsequent imaging procedure is then reimbursed at 50% of the appropriate fee schedule.

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the professional component (Modifier 26) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for the professional component of the second and each subsequent imaging procedure is then reimbursed at 95% of the appropriate fee schedule.

When designated multiple global radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), as any technical or professional components of a designated procedure, the reimbursement of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for the second and each subsequent global imaging procedure is then reimbursed at 50% of the appropriate fee schedule.

This reduction will be applied to Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Ultrasound (US) Radiology services.

In situations where an applicable radiology CPT® code is submitted with more than one unit, the reduction will apply to the second and beyond unit. In situations where two or more radiology CPT® codes are submitted for the same date of service, but only one of the codes is in the applicable reduction code set, then the reduction will not apply.

A reduction will not apply in scenarios:

- where there is more than one separate patient encounter on a given date of service (modifier XE)
- where it is performed on a separate organ/structure (modifier XS)
- where it is performed by a different practitioner (modifier XP)
- where the use of a service is considered distinct because it does not overlap the usual components of the main service (modifier XU)
- where there is a RT/LT modifier appended to a designated imaging procedure

NOTE: When billing radiology codes, and more than one unit is filed for the same procedure/modifier, services should be billed on individual line items. By not complying with the below, a claim may experience delay in reimbursement, rejection of charges or a returned claim. ***Providers should utilize the appropriate modifiers to indicate repeat procedures, multiple distinct procedures performed on same date of service, etc., to clearly delineate the clinical situation to prevent unnecessary denials.***

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

10. 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:

MPFSRVF Indicator	Procedure Rank	Percentage	Explanation
0	1st	100%	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.
0	2nd +	100%	
2	1st	100%	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 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.
2	2nd	50%	
2	3rd	50%	
2	4th	50%	
2	5th	50%	
2	6th +	IC	
3	1st	100%	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.
3	2nd	50%	
3	3rd	50%	
3	4th	50%	
3	5th	50%	
3	6th +	IC	
9	1st	100%	Concept does not apply.
9	2nd+	100%	Concept does not apply.

11. 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.

The final allowable for eligible bilateral procedures will be subject to the lesser of provision found in the provider'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 to indicate the service was performed on both sides of the body. For most CPT codes, only one unit should be reported. However, certain procedures performed bilaterally may be submitted with modifier 50 and multiple units when appropriate.

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.

12. 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 modifiers 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., nurse practitioners and clinical nurse specialists) are considered ancillary support.

Reimbursement for assistant-at-surgery services provided by nurse practitioners or clinical nurse specialist 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 assistant-at-surgery services provided by a nurse practitioner or clinical nurse specialist will be $0.00.

Such services 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 nurse practitioner or clinical nurse specialist should be compensated directly by the supervising Physician or facility.

Eligible assistant-at-surgery services provided by a physician assistant credentialed as a n assistant-at-surgery will be based on the lesser of total covered charges or 13.6% (i.e., 85% of 16%) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a physician assistant who isn't credentialed as an assistant-at-surgery will be $0.00.

Note: Physician assistants must bill assistant-at-surgery services using the unique provider number and/or NPI assigned for this purpose. Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.

13. 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.

14. Discontinued and Reduced Services/Procedures (Modifiers 52, 53, 73, 74)

In surgical or procedural services represented with a CPT code, there are situations where the intended procedure is not fully completed, and these are identified on claims with a modifier 52 or 53, and on facility claims requiring anesthesia, with a modifier 73 or 74.

Specifically, modifier 52 should be attached to codes when the surgeon completed the procedure but did not fulfill all the requirements, and modifier 53 should be used for procedures that are terminated by the surgeon, typically because of the patient's condition. Modifier 52 indicates reduced services, while modifier 53 indicates a discontinued procedure. If the surgeon discontinued the procedure without completing the treatment as planned, use modifier 53. If the service is complete, use modifier 52.

Modifier 73 should be appended to a procedure claim when the procedure is discontinued before planned anesthesia. Modifier 74 will apply when the procedure is discontinued after planned anesthesia. These modifiers apply only to procedures that require anesthesia. They are used to cancel an operation before or after anesthesia is provided. In scenarios where a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure, discontinued services modifiers do not apply.

Effective for claims with dates of service on or after January 1, 2026, BCT will reimburse discontinued or reduced services for providers as follows:

- Reduced Services, identified with a modifier 52, at 50% of the appropriate fee schedule.
- Discontinued Services, identified with a modifier 53, at 25% of the appropriate fee schedule.
- Discontinued Services before planned anesthesia, identified with a modifier 73, at 25% of the appropriate fee schedule.
- Discontinued Services after planned anesthesia, identified with a modifier 74, at 50% of the appropriate fee schedule.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

15. 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.

Note: Effective 1/1/2020, Modifier 63 can be appended to the following codes outside the surgical range indicated above:

92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616.

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.

16. 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.

17. 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

American Academy of Ophthalmology: “EyeNet – Savvy Coder.” Accessed September 19, 2000.

American Academy of Pediatrics. “Eye Examination and Vision Screening in Infants, Children, and Young Adults”. Accessed September 14, 2000.

American Medical Association, Current Procedural Terminology: CPT® 2000. (Chicago: American Medical Association, 1999), p 452.

18. 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

American Medical Association, Current Procedural Terminology: CPT® 2001. (Chicago: American Medical Association, 2000), p 353.

American Medical Association, CPT® Changes 2001. (Chicago: American Medical Association, 2000), p 209.

19. 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.

20. Reimbursement Guidelines for Online Evaluation and Management Services

The American Medical Association established CPT® codes to report an online evaluation and management service to report an online evaluation & management service, per encounter, provided by a physician, or qualified non-Physician health care professional, 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).

The Centers for Medicare and Medicaid Services has also established defined physicians' services furnished using communication technology, several inter-professional internet consultation codes and clinical trial service codes that fall within these same guidelines.

The maximum allowable fee schedule amount for these online evaluation and management and new technology services will be $0.00 even if billed alone with the exception of when the service is approved through an eligible BlueCross BlueShield of 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.

21. 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.

Note: Medicare doesn't allow reimbursement for consultation service CPT® codes 99242-99245 for office and other outpatient consultations and CPT® codes 99252-99255 for face-to-face medical consultations.

Effective for claims with dates of service on or after October 1, 2025, BCT will not reimburse services filed with consultation CPT® codes 99242-99245 and 99252-99255, including when reported with telehealth modifiers.

For these services, claims will be denied, and professional providers will be asked to bill using the Evaluation and Management (E&M) CPT® code which most appropriately describes the type of consultation service provided (e.g., office visit, hospital care, nursing facility care, or home service setting).

22. 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

23. 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".

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.

Exception:

Reporting of maternity CPT codes 0500F (prenatal) and 0503F(postpartum). See details at https://bluecare.bcbst.com/providers/tools-resources/general/healthymom

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

24. 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 52

Description

Reduced Services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual.)**

Modifier 53

Description

Discontinued Procedures

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual.)**

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.
- 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 73

Description

Discontinued outpatient hospital or ASC procedure before the administration of anesthesia. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual.)**

Modifier 74

Description

Discontinued outpatient hospital or ASC procedure after the administration of anesthesia. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual.)**

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 one example of a multipurpose modifier for professional claims and can be used to identify gender-specific services, Chimeric Antigen Receptor (CAR) T cell therapy, or signal on a claim that although the patient services have met the capped amount allowed, the provider deems continued care medically necessary.

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.

(Also, refer to the **Use of Imaging Studies for Uncomplicated Low Back Pain** Policy sub section of this Provider Administration Manual for additional use of the KX Modifier).

25. 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

https://www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-edit-files

26. 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.

27. 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

1. The AWP/WAC based on the National Drug Code (NDC) for the specific product billed.

Method 2

1. For a single-source product, the AWP/WAC equals the AWP/WAC of the single product.
2. 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 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 OptumRX Program are not billable to or reimbursable by the BlueCare or TennCare*Select* Networks. Refer to OptumRX Program billing guidelines further into this section.

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). If there is no published ASP, the maximum allowable is based on a percentage of Wholesale Acquisition Cost (WAC). If neither ASP nor WAC is published, maximum allowable shall utilize Average Wholesale Price (AWP). ASP, WAC, and AWP are identified using 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 **Exhibit A** below for network percentages of AWP/ASP/WAC. **Please Note:** For Providers who are contracted on the Tiered Drug Fee Schedule for Injectable Drugs, the Tiered Drug Fee Schedule for Injectable Drugs shall prevail over the identified network percentages contained within Exhibit A.

Exhibit A

Percentage of Average Wholesale Price (AWP)/Average Sale Prices (ASP)/Wholesale Acquisition Cost (WAC) by Network

Network	Network Percentage of AWP	Network Percentage of ASP	Network Percentage of WAC
BlueCare	90%	106%	110%
TennCare*Select*	90%	106%	110%

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

Modifier JW should be reported for drug units that were discarded. Providers are responsible for using the most economical packing of medication to achieve the required dosage with the least amount of medication wastage necessary or per manufacturer's directions. Wastage shouldn't be billed for medications available in multi-dose vials (MDV) and isn't reimbursable.

Effective July 1, 2023, CMS requires JZ modifier on all claims for single-dose containers where there are no discarded amounts. Billing guidelines with examples are provided in these sources:

Sources:

CR 9603-JW Modifier: Drug amount discarded/not administered to any patient

Internet Only Manual (IOM) 100-4-Claims Processing Manual; Chapter 17-Drugs and Biologicals; Sections 40-41.1

Discarded Drugs and Biologicals – JW Modifier and JZ Modifier Policy Frequently Asked Questions (cms.gov)

To report claims with drug waste, submit two separate claim lines. One line should contain the HCPCS for the administered drug with no modifier, number of units and price calculated for the administered units only. A second line should report the HCPCS for the administered drug, with modifier JW to indicate

amount wasted, number of units wasted, and the price calculated for the wasted units only. The total units for the two lines should not exceed the units contained in the most economical single dose vial.

To report claims that have no waste, only one claim line should be submitted. This line should contain the HCPCS code for the drug administered, with modifier JZ to indicate there was no waste, the appropriate units of the drug administered and the price for the administered units.

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

BlueCare Tennessee (BCT) doesn't reimburse these medications separately whether administered in the facility, office or dispensed for home use. Charges billed of BCT for self-administered medications will be denied indicating that the charges must be billed to the TennCare Pharmacy Benefit Manager.

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 Sale Price (ASP). If there is no published ASP, the maximum allowable is based on a percentage of Wholesale Acquisition Cost (WAC). If neither ASP nor WAC is published, maximum allowable shall utilize Average Wholesale Price (AWP). ASP, WAC, and AWP are identified using 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 Sale 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.

Source B

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. **Please Note:** For Providers who are contracted on the Tiered Drug Fee Schedule for Injectable Drugs, the Tiered Drug Fee Schedule for Injectable Drugs shall prevail over the identified network percentages contained within Exhibit A.

Exhibit A

Percentage of Average Wholesale Price (AWP)/Average Sale Price (ASP)/Wholesale Acquisition Cost (WAC) by Network

Network	Network Percentage of AWP	Network Percentage of ASP	Network Percentage of WAC
BlueCare	90%	106%	110%
TennCare*Select*	90%	106%	110%

- 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) 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/TennCare*Select* 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. Reimbursement Policy and Billing Guidelines for Professional Providers on the Tiered Drug Fee Schedule

BCT shall reimburse professional providers contracted with the Tiered Drug Fee Schedule for eligible drug codes based on a percentage of Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC). In the absence of both ASP and WAC, Average Wholesale Price (AWP) shall be used. The table below indicates the Base Drug Fee Schedule pricing for each of the above methodologies.

Professional Tiered Base Drug Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

- Tier 1 – Traditional
- Tier 2 – Biosimilars
- Tier 3 – Specialty Drugs
- Tier 4 – Ultra High Cost

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST's policy for Unlisted, Miscellaneous, Non-Specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes."

New codes will default to Tier 4 until the April 1 update at which time they will be placed in the appropriate Tier.

ASP, WAC, and AWP are identified using one of the following sources:

Source A

ASP as defined and published by the Centers for Medicare & Medicaid Services (CMS) on the "Medicare Part B Drugs Average Sales Price" file.

BlueCare Tennessee shall update maximum allowables for eligible drugs published by Medicare Part B – Tennessee in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

Source B

Maximum allowables for drugs not published by Medicare Part B – Tennessee will be calculated based on a percentage of WAC/AWP 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 the generic forms of the drug or the lowest brand name product WAC/AWP.

We reserve the right to select the calculation method and published source for WAC/AWP for drugs without published ASP CMS.

To determine eligibility and reimbursement for a drug, we reserve the right to request the name of the drug, NDC, specific dosage administered and number of units, based on the specific code description. For items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code, specific dosage administered should be reported in the appropriate form and number of units.

In the circumstance that an inappropriate payment has occurred, BCT reserves the right to re-coup the reimbursement as necessary.

k. 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 TennCare's OptumRX Program.

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.

19. RESERVED FOR LOCAL USE N468209084301 Octagam 500 mg/kg IV divided Wt. 150 lbs.														
N468209084304 GM17 ZZOctagam														
12	01	XX	12	02	XX	12		J1568			A	XXXX	xx	68
12	01	XX	12	01	XX	12		S9379			A	XX	xx	1
12	02	XX	12	02	XX	12		S9379			A	XX	xx	1

- 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.

19. RESERVED FOR LOCAL USE **Rocephin 1 Gm IV q12h x5d**														
N4xxxxxxxxxx GM2 ZZRocephin														
12	01	XX	12	06	XX	12		J0696			A	XXX	xx	40
12	01	XX	12	01	XX	12		S9501			A	XX	xx	1
12	02	XX	12	02	XX	12		S9501			A	XX	xx	1
12	03	XX	12	03	XX	12		S9501			A	XX	xx	1
12	04	XX	12	04	XX	12		S9501			A	XX	xx	1
12	05	XX	12	05	XX	12		S9501			A	XX	xx	1

12	06	XX	12	06	XX	12		S9501			A	XX	xx	1

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.

19. RESERVED FOR LOCAL USE **Abcxyz 400 mg IV q8h x3d**														
N4xxxxxxxxxx ME400 ZZAbcxyz														
12	01	XX	12	01	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx GM1.2 ZZAbcxyz														
12	02	XX	12	02	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx GM1.2 ZZAbcxyz														
12	03	XX	12	03	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx ME800 ZZAbcxyz														
12	04	XX	12	04	XX	12		J3490			A	XXX	xx	1

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 Tennessee 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 OptumRX Program are not billable to or reimbursable by BlueCare or TennCare*Select* Networks.
- (Refer to OptumRX Program billing guidelines further in this section.)
- 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.

Code	Type of Service	Description
S5498	Single Lumen	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem
S5501	Multiple Lumens	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S5502	Implanted Access Device	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)

PAIN MANAGEMENT

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9326	Continuous Infusion	Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9327	Intermittent Infusion	Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9328	Implanted Pump Instillation	Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

CHEMOTHERAPY

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9330	Continuous Infusion	Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9331	Intermittent Infusion	Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

EPOPROSTENOL

Code	Type of Service	Description
S9347	Uninterrupted Infusion	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

TOCOLYTIC

Code	Type of Service	Description
S9349	Infusion Therapy	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

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.

Code	Type of Service	Description
S9374	1 Liter	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
S9375	2 Liters	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
S9376	3 Liters	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

TOTAL PARENTERAL NUTRITION

Code	Type of Service	Description
S9379	TPN and / or lipids	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

ANTI-INFECTIVE

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9500	Q 24 hours	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

S9501	Q 12 hours	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
S9502	Q 8 hours	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
S9503	Q 6 hours	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
S9504	Q 4 hours	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

MISCELLANEOUS

Code	Type of Service	Description
S9379	Infusion Therapy	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

- 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, TennCare*Select*, or CoverKids for secondary payment.
- Secondary claims for HIT services must be filed with the appropriate Medicare Part B and D electronic remittance advices 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/.

l. 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

m. 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).

n. Epidural Steroid Injections

Effective April 1, 2023, Epidural Steroid Injections no longer require prior authorization. Epidural Steroid Injections in excess of three injections during any period of six consecutive months, except epidural injections associated with childbirth, are excluded from coverage under the TennCare program. Billing in excess of three Epidural Steroid Injections in any period of six consecutive months will result in recoupment of reimbursement.

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.

28. 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 on our website at: 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 view the budget reduction memo located on our website for more information.

a. Durable Medical Equipment (DME) and Medical Supplies

Note: Durable Medical Equipment Reimbursement Methodology applies to BCT contracts only.

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.

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.

For DME provider types this could include POS codes: 04, 09, 12, 13, 14, 16, 27, 32, 33, 34, 54, 55, 56, and 99 as possible member residence.

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:

Modifier	Description
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with surgical dressing
KE	Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment
KF	Item designated by FDA as class III device
KL	DMEPOS item delivered by mail
KR	Rental item, billing for partial month
NU	New equipment
RR	Rental (use the 'RR' modifier when DME is to be rented)
UE	Used durable medical equipment

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 Palmetto GBA, LLC website at https://www4.palmettogba.com/pdac_dmecs.

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 enterals, 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.
- 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.
- Remote therapeutic monitoring treatment/assessment services furnished personally/directly by a non-physician qualified health care professional, are considered professional services and are not billable by the DMEPOS/Supplier Provider.

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 OptumRX Program.
- Items included in the State of Tennessee Division of TennCare’s OptumRX Program are not billable to or reimbursable by the BlueCross BlueShield of Tennessee BlueCare or TennCare*Select* Networks. (Refer to the OptumRX program billing guidelines further in this section.)

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.

    Note: If different formulas which share the same HCPCS code are provided, only a single line item of the code should be billed. The units should indicate the total calories (i.e., 1 unit = 100 calories) of all formulas supplied with this same code during the same span date. The NDC and/or product name of one formula may be reported in the "Additional Information" section (See Additional Information section above). Block 19 – Reserved For Local Use, section of the CMS-1500 or its electronic equivalent, may be utilized if reporting of additional NDC/formula product information is required. Billing multiple lines of the same formula code for the same span date may result in delay of 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, 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.

Coverage for Complex Rehab Technology Maintenance

- Effective **July 1, 2024,** BlueCare, TennCareSelect and CoverKids cover and reimburse medically necessary repairs on complex rehab technology (CRT) annually for at least one preventive maintenance visit. The repairs must be provided by an authorized CRT equipment supplier.
- CRT providers are required to complete the Tennessee Department of Commerce and Insurance's CRT Attestation Form Tennessee Department of Commerce and Insurance's CRT Attestation Form and submit it with the initial claims submission. All paid claims are subject to provider audit and recoupment if no attestation form is on file.
- For questions about billing for CRT maintenance, please refer to this grid:

Approach to Identify Wheelchair Device	**Use Wheelchair code + MS modifier** for Data Reporting/Segmentation of device (No payment)
Approach to Identify and Reimburse for Maintenance Service Only	Line 1 Billed on Claim – Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim – K0739MS (Indicates Maintenance; Results in Payment)
Approach to Identify and Reimburse for a Combined Visit of Repair and Preventative Maintenance Services	Line 1 Billed on Claim – Wheelchair code + MS modifier (No payment)
	Line 2 Billed on Claim – K0739 + MS modifier (Indicates Maintenance; Results in Payment)
	Line 3 Billed on Claim – K0739 (without modifier) (Indicates Repair; Results in Payment)
Approach to Identify and Reimburse for a Repair Service Only.	Line 1 Billed on Claim – Wheelchair code + MS Modifier (No payment)
	Line 2 Billed on Claim – K0739 (without modifier) (Indicates Repair; Results in Payment)

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 Palmetto GBA, LLC website at https://www4.palmettogba.com/pdac_dmecs.

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:

Published Medicare Fee for Capped Rental x three (3) months x 100%

\+ Published Medicare Fee for Capped Rental x ten (10) months x 75%

= Medicare Purchase Fee

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:

Published Medicare Fee for Capped Rental x three (3) months x 150%

\+ Published Medicare Fee for Capped Rental x ten (10) months x 60%

= Medicare Purchase Fee

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 on separate claim lines using the LT modifier on one line, the RT modifier on the other line, and 1 unit of service per line.

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:
  - DMEPOS 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 Palmetto GBA, LLC website at https://www4.palmettogba.com/pdac_dmecs.

- 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 to 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

Eff. 4/1/23 DME Policy Guidelines Updated:

Codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable requires submission of the manufacturer name, product name, product number, and quantity.

The maximum allowable for these services will be based on the lesser of total covered charges or the following percentages of the manufacturer's published list price as determined by BlueCare Tennessee (BCT):

100%	Medical Supplies
100%	Durable Medical Equipment
100%	Orthotics
100%	Prosthetics

An invoice including the member's name, purchase or rental date, product name, product/model number, product make, supplied/provided, is required. If multiple items are on the invoice, the correct item(s) is to be clearly indicated. Reimbursement will be based on the initial submission for payment (e.g., unaltered manufactured/supplier's invoice indicating the product acquisition cost after all discounts and rebates, online manufacturer order forms, and online manufacturer retail price lists).

BCT reserves the exclusive right to determine the manufacturer's visibly published and date of service appropriate published list price. Manufacturer information must be published on a secure website, unsecure websites will not be used to verify manufacturing pricing. Sources used by BCT to determine the manufacturer's published list price include, **but are not limited to:**

Information visibly published by the manufacturer (e.g., product catalogs, product price listings, manufacturer online order forms).

In the event BCT is unable to verify the list price using one of the aforementioned visibly published and date of service appropriate sources, BCT 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 total covered charges or 120 percent of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to:

- durable medical equipment, medical supplies, orthotics, and prosthetics billed on the Professional claim form; and
- medical supplies on the BCT Home Health Non-routine Supply List billed by a home health agency on the Institutional claim form.

Reimbursement for codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable is subject to the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, BCBST/BCT billing and reimbursement guidelines.

f. Respiratory Care Supplies & Equipment Providers

Effective 1/1/2020, complex respiratory supplies and equipment can only be provided by providers who are contracted for these codes. For a list of contracted providers and the codes, please contact Customer Services at 1-800-468-9736.

29. 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 Tennessee 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. TN – T2 Program

The Triage, Navigate, Treat and Transport (TN-T2) is a payment model to provide greater flexibility to emergency medical services (EMS) care teams to address emergency health care needs of TennCare beneficiaries following a 9-1-1 call. The goals of the model are to provide person-centered care, increase efficiency in the EMS system, and encourage appropriate utilization of emergency medical services. Essentially this provides a method for BCT reimbursement for treatment-in- place (TIP) and transport to alternate destinations (TAD).

The TN-T2 program is designed to:

- provide person-centered care such that individuals receive care safely at the right time and place;
- to increase efficiency in the EMS system by allowing EMS providers increased opportunity to respond to high-acuity cases; and
- to encourage appropriate utilization of emergency medical services to meet health care needs effectively.

Under the TN-T2 Model, BCT will continue to pay for emergency transport of a TennCare beneficiary to a hospital Emergency Department (ED) or other destination covered under current TennCare requirements. Additionally, BCT will pay providers who are TennCare-enrolled ambulance suppliers to:

1. Transport a beneficiary to an Alternative Destination Partner such as an Urgent Care Clinic, Federally Qualified Health Center, or Community Mental Health Center (Transport to an Alternative Destination - TAD) [**Note**: transport to a primary care provider is disallowed], or
2. Initiate and facilitate beneficiary receipt of a medically necessary covered service by Qualified Healthcare Partner (QHP) or Downstream Practitioner at the scene of a 9-1-1 response, either in-person on the scene or via telehealth (Treatment in Place - TIP).

A Qualified Healthcare Partner provides covered services to TN-T2 Model Beneficiaries as part of an In-Person Treatment in Place Intervention or Telehealth Treatment in Place intervention. Examples of a Qualified Healthcare Partner include, but are not limited to, a TennCare-enrolled group practice, a TennCare-enrolled physician or non-physician practitioner, or a non- TennCare enrolled entity that contracts or employs a TennCare-enrolled physician or non-physician practitioner to furnish services to TN-T2 Model Beneficiaries as part of a Treatment in Place intervention. As a reminder, the QHP or the alternate destination must be contracted with BCT.

An individual practitioner must be a physician or non-physician practitioner who meets all State and local laws, regulatory requirements, accreditation standards, and licensing guidelines or rules to render the particular TennCare-covered service furnished to the TN-T2 Model Beneficiary as part of a Treatment in Place intervention. Unless also licensed as a physician or non-physician practitioner, paramedics and emergency medical technicians (EMTs) are not eligible to enroll in TennCare at the individual practitioner level, and therefore do not meet the standard for a Qualified Healthcare Provider under this Model.

Claims for TN-T2 services shall be submitted to the BCT through normal procedures. EMS providers who provide these services must submit the following claims modifiers - placed in the “destination” position (not the origin position) of the EMS provider claim for TAD and TIP claims:

Service Provided	Modifier
Transport to Alternate Destination (TAD)	C: Community Mental Health Center
	F: Federally Qualified Health Center
	U: Urgent Care
Treatment in Place (TIP)	W: Treatment by QHP in-person or via telehealth*

*mileage charges are not applicable for TIP claims

Claims for TAD and TIP are subject to medical necessity determinations and include adjustments for geographic factors/add-ons, and multiple-patient rule, as applicable. Mileage adjustments must not be included in TIP claims.

If a TennCare member refuses TIP (on-scene or telehealth) or TAD services, and must be transported to the Emergency Department, the claim should be filed with both the appropriate ALS or BLS code and the procedure code G2022, which indicates that the member was transported to the Emergency Department. In a scenario where a TennCare member receives TIP (treatment in place by EMS or via telehealth by a QHP) and the TennCare member still ends up having to be transported to the ED, then the EMS agency will be paid for the final intervention that was delivered, which is the transport to the ED. The EMS agency will not be paid for both. However, the QHP will be paid for their TIP intervention even if the member ends up being transported to an ED.

For additional billing instructions and guidelines on how to bill claims for dual eligible members, please reference the TN-T2 Program memo from the Division of TennCare at: https://www.tn.gov/content/dam/tn/tenncare/documents/TNT2FAQRevised9222023.pdf

c. 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 Verida. NEMT Providers should complete the Trip Reimbursement Form (Driver Log) and submit to Verida. Verida will convert the Trip Reimbursement Form to the correct HCPCS codes (A-codes) and submit the information to BlueCare/TennCare*Select* via encounter data reporting. Mail non-emergency transportation Trip Reimbursement Forms to:

Verida, Inc.
843 Dallas Highway
Villa Rica, Georgia 30780

d. Billing Guidelines for Ambulance Services

Claims filed to BlueCare Tennessee 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 Tennessee 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>.

30. Newborns (Applies to CoverKids effective DOS 1/1/2021)

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.

31. Medication Therapy Management 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 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 our Members get the best benefits from their medications by managing drug therapy and by identifying, preventing, and resolving medication-related problems.

The program 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.

The following grid describes Medication Therapy Management (MTM) Reimbursement Guidelines:

Service Description	Modifier Code	Case Rate	Payment Limits (Annual)	Units
Low	U1	$55.00 (Eff. 1/1/20)	2 Months	1 unit for each case rate
Moderate	U5 (Eff. 7/6/20)	$55.00 (Eff. 7/6/20)	2 Months	1 unit for each case rate
Medium-High	U2	$55.00 (Eff. 1/1/20)	3 Months	1 unit for each case rate
High-Critical	U3	$75.00 (Eff. 1/1/20)	6 Months	1 unit for each case rate
Exceptions (Requires appropriate approval)	U4	Rate based on level of care modifier	Limit based on appropriate approval	1 unit for each case rate

The pharmacist must check the Quality Care Rewards (QCR) application through the Availity website to determine if the BlueCare Tennessee member is eligible for the MTM program and to determine which modifier to bill for the services that were provided. You can view the MTM eligibility indicator on these two reports under the Quality Reports tile:

- TennCare MCO – Patient-Centered Medical Home (PCMH) Weekly Attribution Report
- TennCare MCO – Tennessee Health Link (THL) Weekly Attribution Report for PCMH and THL

These reports also include a field for Risk-Level showing each member's risk level. You will need this information to determine which modifier codes to use on claims.

Modifiers U1 – U3 and U5 (eff. 7/6/2020) should be filed in the first modifier position for CPT® codes 98966, 98967, 98968, 99605, and 99606.

Modifier U4 should be filed in the second modifier position for CPT® codes 98966, 98967, 98968, 99605, and 99606.

- The Provider is to file one unit for each 15 minutes.
- The reimbursement will be considered Case Rates. Only one claim will be paid per month regardless of the Provider of service.

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 an MTM exception (ME) form and send 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 and approved . BlueCare Tennessee will review the ME form for completeness to determine reimbursement appropriateness. 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 program and the credentialing/contracting requirements please refer to the Division of TennCare's website at Medication Therapy Management Pilot Program (tn.gov)

32. Reimbursement Policy for CPT® Category III Codes

Beginning May 1, 2020, the BlueCare Tennessee reimbursement for CPT® Category III codes and all related services will be $0.00. These codes are used to track the use of emerging technologies, services and procedures and they do not establish a service or procedure as safe, effective or Medically Necessary.

BCT is introducing this policy based on Medicare guidelines established by the Centers for Medicare & Medicaid Services' National Coverage Policy. If Medicare develops a price for a CPT® Category III code, BCT may allow payment. We may also allow payment if the service is approved through an initiative, such as telehealth or telemedicine, or one of our medical directors approves payment for a specific case following a medical review.

33. Use of Imaging Studies for Uncomplicated Low Back Pain

One measure we collect for the National Committee for Quality Assurance (NCQA) evaluates the appropriate use of imaging studies for uncomplicated low back pain (LBP). This measure evaluates the percentage of members ages 18 to 75 diagnosed with LBP who:

- Haven't received a prior diagnosis of LBP in the past six months
- Haven't had diagnostic imaging studies within the first 28 days of the diagnosis (including plain film radiographs, MRI and CT scans)

When treating a patient with low back pain (LBP), it's important to document and code for any exclusions that would warrant use of imaging studies. Patients with a diagnosis of uncomplicated LBP should wait 28 days or more after receiving a primary diagnosis before they undergo a diagnostic imaging study (plain film radiographs, MRI, or CT scan).

Diagnostic Imaging services may be appended with the use of modifier KX to indicate that NCQA HEDIS® exclusionary criteria were met. Any required prior authorization for the imaging study must still be obtained.

These exclusionary criteria include:

At any time before the advanced diagnostic imaging study

- Diagnosis or history of cancer; or
- HIV infection; or
- Major organ transplant on immunosuppression therapy; or
- Evidence of osteoporosis therapy; or
- Prior lumbar spine surgery; or
- Spondylopathy diagnosis

Within 12 months before the advanced diagnostic imaging study

- IV drug abuse: or

- Neurologic impairment; or
- Spinal infection; or
- Prolonged corticosteroid use for 90 days consecutively; or
- Hospice services; or
- Palliative care services.

Within six months but more than 28 days before the advanced diagnostic imaging study

- Uncomplicated low back pain

Within three months before the advanced diagnostic imaging study

- Recent trauma; or
- Fragility or osteoporosis fracture of the spine

If any one of the above exclusions has been met, then use of the KX modifier on the claim is appropriate, assuming any required prior authorization for the imaging study was obtained. If none of the above is applicable to the member, then use of the KX modifier is not appropriate due to potential improper use of diagnostic imaging studies for a diagnosis of uncomplicated low back pain. By using the KX modifier, Providers are attesting that the imaging study meets medical necessity requirements.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

34. Advanced Practice Health Care Practitioner (APHCP) Policy

Effective with dates of service on or after August 15, 2025, BlueCare Tennessee (BCT) will pay for services furnished by APHCPs based on CMS payment policy.

- This policy applies to APHCPs as defined by BCT and includes the following credentialed provider specialties (including any sub-specialties to these specialties):
  - Physician Assistant
  - Nurse Practitioner (excluding Psychiatric/Mental Health sub-specialty)
  - Clinical Nurse Specialist
  - Nutritionist
  - Dietitian
  - Certified Nurse Midwife
- This policy applies to services furnished by all APHCPs, regardless of whether they contract with BCT to participate in a BCT provider network (i.e., regardless of whether the professional is an “in-network” or “out-of-network” provider).

Note: If you are a Behavioral Health provider, and your BlueCare and/or TennCare Select Agreement includes Network Attachments that support the CMS RBRVS reimbursement methodology, we will apply the same reductions applied by CMS for Master’s level and Midlevel providers.

Payment Guidelines

- In accordance with its general policy, BCT pays APHCP professional services only when the service is covered under the member’s benefit plan and claims for such services follow the guidelines and requirements set forth by BCT.
- APHCPs must submit claims using their individual NPI number when rendering services to members. See “Staff Supervision Requirements or Delegated Services, Provider Categories/Billing and Supervision Requirements, Licensed Providers Requiring Supervision by Retrospective Review” for more information.
- BCT pays APHCP professional services at 85% of the physician’s rate under the allowed amount pursuant to the applicable professional fee schedule.
- For BCT’s guidelines for assistant-at-surgery services, please refer to the Assistant-at-Surgery Policy of this subsection.
- For BCT’s guidelines for “incident to” services, please refer to the Incident to Services and Supplies Policy of this subsection.

35. Incident To Services & Supplies

Effective with dates of service on or after August 15, 2025, BCT will pay for "incident to" services furnished by Supervising Health Care Practitioners and APHCPs based on CMS payment policy.

"Incident to" services and supplies are those provided as an integral, although incidental, part of the Supervising Health Care Practitioner's personal professional services during diagnosis and treatment.

- This policy applies to Supervising Health Care Practitioners and APHCPs.
- This policy applies to services furnished by all Supervising Health Care Practitioners and APHCPs, regardless of whether they contract with BCT to participate in a BCT provider network (i.e., regardless of whether the professional is an "in-network" or "out-of-network" provider).

For purposes of this policy, "Supervising Health Care Practitioners" are physicians and nonphysician practitioners who are authorized to have services provided by APHCPs. Supervising Health Care Practitioners include medical clinicians described as autonomous providers in the Staff Supervision Requirements for Delegated Services policy, such as MDs, DOs, DCs, and DPMs.

For purposes of this policy, only APHCPs have the option of providing services incidental to the professional services of a Supervising Health Care Practitioner.

Payment Guidelines

- In accordance with its general policy, BCT pays for incident to services and supplies only when the service is covered under the member's benefit plan and claims for such services follow the guidelines and requirements set forth by BCT.
- APHCPs must submit claims using the Supervising Health Care Practitioner's NPI number when rendering incident to services to members and append the SA modifier to such services.
- BCT pays incident to services and supplies only when the services comply with applicable state and federal law and meet all requirements set forth by CMS for incident to services and supplies.

J. Staff Supervision – Requirements for Delegated Services

This policy defines our requirements for supervision by eligible professional Providers of their associate and assistant practitioners. For specific information on behavioral services and any supervision or billing requirements applicable to behavioral health practitioners, please see the full Behavioral Health Services section of this Manual.

Supervision alone doesn't create eligibility for the services of associate and assistant practitioners. Such practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement.

This policy, together with the Incident To Services & Supplies policy, also describes requirements for billing delegated services. To the extent state or federal law or regulation exceeds these internal requirements, those laws or regulations will control.

Autonomous Providers

Autonomous providers are Providers who by their state license are qualified to diagnose and initiate treatment independently, and who do not require supervision. Providers in this autonomous category are required to complete our full credentialing process and bill us directly under their own provider NPI.

Licensed Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Chiropractic (DC), Doctors of Podiatric Medicine (DPM), Licensed Genetic Counselors, Licensed Pharmacists, Licensed Physical Therapists, Certified Occupational Therapists, Registered Dietitians / Registered Nutritionists, Lactation Consultants (IBCLC), Speech and Language Pathologists, and Certified Audiologists are all examples of autonomous providers. Their services don't require supervision or orders from another professional.

For specific information on providers of Lactation Services (other than Lactation Consultant (IBCLC) credentialed by BCBST), including supervision and billing requirements, please see "OB/GYN Services" earlier in this section of the Manual.

<u>Specific Billing Requirements:</u>

Block 24J – Practitioner rendering the service

A specific modifier explaining the NPI listed in this block may be required. Please see the specific billing requirements set forth in the Billing and Reimbursement Guidelines section of this Provider Manual.

Note: Billing Requirement for Physical, Occupational and Speech Therapy Services

Per CMS guidelines, physical, occupational and speech therapy services are defined as services ordered/referred/prescribed by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law. To comply with these guidelines, professional claims submitted for these therapy services without the ordering or referring provider listed will be rejected.

Delegated Services

An eligible Provider may delegate services to be performed by other practitioners. Such services must be covered under the benefit contract, performed under appropriate supervision, and billed according to the policies set forth by BCBST. Services performed by an APHCP, as that term is defined earlier in this section, must be billed according to the APHCP policy, in conjunction with the Incident To Services and Supplies policy.

Practitioners not specifically mentioned in this policy, or in another section of this Manual, aren't eligible to have services delegated to them.

- Practitioner services can be delegated to:
- Certified Anesthesiologist Assistant*
- Certified Athletic Trainer
- Certified Chiropractic Therapy Assistant
- Certified Medical Assistant
- Certified Nurse Midwife*
- Certified Nursing Assistant
- Certified Occupational Therapy Assistant
- Certified Podiatric Assistant
- Certified Registered Nurse Anesthetist*
- Chiropractic Radiology Technician
- Licensed Physical Therapy Assistant
- Licensed Practical Nurse
- Licensed Resident Physician
- Medical Laboratory Technician
- Medical Laboratory Technologist
- Nurse Practitioner*
- Physician Assistant*
- Radiologic Technologist
- Registered Nurse
- Registered Respiratory Therapist
- Speech Language Pathology Assistant

While classified as Delegates because they do not fall within the "autonomous" definition, professional practitioners listed above with an (*) must be individually enrolled with BlueCross and bill their services under their own NPI. The supervising practitioner may not bill for services delegated to these practitioners unless rendered by an APHCP and the services fall within the requirements of the Incident To Services & Supplies policy. More details on billing requirements for these Delegates, depending on the level of supervision required, are listed below or in the Billing and Reimbursement Guidelines of this Provider Manual for specific services.

Delegate Categories for Billing and Supervision Requirements

Licensed or Certified Practitioners Requiring Supervision by Retrospective Review

Retrospective review refers to supervision conducted after a service has been rendered, rather than during its performance. It may occur days or weeks later and typically involves reviewing a patient's medical record (e.g., complaints, signs, symptoms, diagnostics, and treatments). The supervising practitioner is typically not present at the site of service when the delegated service is performed.

Licensed providers requiring supervision by retrospective review include, but are not limited to, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Licensed Resident Physicians, Nurse Practitioners,

and Physician Assistants. Supervising practitioners must review delegated services and comply with all requirements and regulations of the applicable licensing or certification board.

Delegate Providers in this category must complete the full BlueCross credentialing and contracting process and submit claims with their own NPI as the rendering provider. This requirement doesn't apply to:

- Practitioners rendering services at health departments,
- Licensed residents when performing services that are a part of their residency program, or
- Services performed by APHCPs that fall within the requirements of the BCBST Incident To Services & Supplies policy.

Specific Billing Requirements:

Block 17 – Supervising Practitioner

To indicate the role of the Provider being reported, enter the appropriate qualifier (DQ for Supervising Provider) to the left of the vertical, dotted line. The name of the Provider being reported should be entered to the right of the vertical, dotted line.

Block 24J - Practitioner rendering the service

Note: Claims not submitted according to the above billing guidelines are subject to denial unless submitted according to BCBST's Incident To Services & Supplies policy.

Additional Note: For nurse practitioners and physician assistants, Member copays for all lines of business (excluding Federal Employee Program members, Postal Service Health Benefits members, and BlueCard) will be based on whether the supervising physician reported in Block 17 is a primary care or specialist provider. Please note, our implementation of this guideline has been postponed to a later date to allow additional time for providers to adopt these billing requirements. The effective date will be communicated in a BlueAlert publication.

Licensed or Certified Practitioners Requiring Minimal Supervision

Supervising practitioners must perform all requirements and follow all regulations set forth by the applicable medical licensing or certification board for each provider type falling under this subsection. At a minimum, this level of supervision requires the supervising practitioner to:

- Evaluate the patient at some reasonable time before the delegated service;
- Issue a specific written order for the service prior to the service being performed; and
- Document the results of the delegated service.

The supervising practitioner doesn't have to be within the place of service (e.g., facility, office) when the delegated service is rendered.

Licensed Providers requiring minimal supervision include Certified Athletic Trainers, Chiropractic Radiology Technicians, Licensed Physical Therapy Assistants, Licensed Practical Nurses, Medical Laboratory Technologists, Certified Occupational Therapy Assistants, Radiologic Technicians, Registered Nurses, and Registered Respiratory Therapists. These practitioners are not independently credentialed or contracted by BCBST or eligible to bill separately for their services.

Supervising practitioners must also:

- Annually review and document the licensure or certification of any practitioner to whom they delegate medical services
- Delegate only services within the delegate practitioner's legal scope of practice, as defined by certification or license, and that don't require independent professional judgement.
- Maintain documentation including:
    - Patient evaluation prior to delegating or ordering any services;
    - A specific order for the delegated service;
    - Results of the service ordered; and
- Use treatment protocols from nationally recognized professional sources, available on-site for review.

Specific Billing Requirements:

Supervising practitioners 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 licensed practitioner to legally perform a service and is ineligible to bill under their own NPI pursuant to the terms and conditions of their license or certification, then such supervising practitioner will be allowed to bill those services under their name and NPI.

Section 53107 of Bipartisan Budget Act (BBA of 2018) added a new section 1834(v) of the Social Security Act, which required the Centers for Medicare and Medicaid Services (CMS) to establish two modifiers to be used when applicable for services furnished in whole or in part by a Physical Therapy Assistant (PTA) and Occupation Therapy Assistant (OTA) under a physical therapy or occupational therapy plan of care. The modifiers are being assigned to identify therapy services based on specific time converted into units for PTAs and OTAs where reimbursement should be reduced separate from the treating or supervising practitioner's services.

Effective for dates of 7/1/2022 and after, BlueCare Tennessee will apply CMS guidelines related to physical and occupational therapy services furnished in whole or in part by PTAs and OTAs by requiring the use of a CQ or CO modifier as appropriate and limiting reimbursement of those services at 88% of the applicable fee schedule. The modifiers are defined as follows:

- CQ modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant.
- CO modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant.

Certified Practitioners Requiring Direct and Close Supervision

Direct and close supervision requires the supervising practitioner to be onsite and readily available, with face-to-face contact with the patient immediately before and after a delegated service. The supervising practitioner must materially participate by evaluating the patient prior to the service, issuing a detailed written order, and performing a final evaluation before the patient leaves the facility or office. Being available via telephone doesn't constitute direct and close supervision. (**Note**: See *Extenuating Circumstances* below.)

With the exception of the Certified Anesthesiologist Assistant, the following health care practitioners aren't independently credentialed or contracted by BCBST and are ineligible to bill directly for services:

- Certified Anesthesiologist Assistant
- Certified Chiropractic Therapy Assistant
- Certified Medical Assistant
- Certified Nursing Assistant
- Certified Podiatric Assistant
- Medical Laboratory Technician
- Speech Language Pathology Assistant

Supervising practitioners must meet all requirements and regulations set forth by the applicable medical licensing or certification board for each provider type falling under this type of supervision. At a minimum, supervising practitioners must:

- Annually review and document the licensure or certification of any delegated staff or practitioners;
- Delegate only services in which they materially participate – this means evaluating the patient immediately prior to the service, preparing a detailed written order, and performing a final evaluation of the patient and the service performed prior to the patient leaving the facility or office that ensures the service was delivered appropriately and was clinically effective.
- Remain on site and available at all times while the service is rendered;
- Document in the patient medical record that these supervision steps occurred;
- Follow nationally-recognized treatment protocols, which must be kept onsite and available for review; and
- Only delegate services that don't require independent clinical judgement or couldn't be construed as services requiring the expertise of practitioners in either of the above supervision categories.

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 supervising practitioner doesn't have to be physically present or on the premises.

Specific Billing Requirements:

For Certified Anesthesiology Assistants:

Block 17 – Supervising Practitioner

To indicate the role of the Provider being reported, enter the appropriate qualifier (DQ for Supervising Provider) to the left of the vertical, dotted line. The name of the Provider being reported should be entered to the right of the vertical, dotted line.

Block 24J – Practitioner rendering the service

K. Locum Tenens Policy

A "locum tenens" is a temporary Practitioner who fills in for a participating Practitioner on a short-term basis. A "locum tenens" is only allowed to serve as the substitute practitioner for the participating Practitioner for up to 60 (sixty) days. A Practitioner who is to be a permanent member of a practice or who performs services for over 60 (sixty) days does not meet the definitions of a "locum tenens". In order to become a permanent member of the practice or continue performing services to members, the locum tenens 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 cannot 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 locum tenens generally does not have a practice of his/her own and moves from area to area as needed. The participating practitioner generally pays the locum tenens or an agency a fixed amount per diem, giving the locum tenens 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 of the practice, and whose services for Members of the participating Practitioner are not restricted to the participating Practitioner's office, if:

- The Member has arranged or seeks to receive services from the participating Practitioner;
- The participating Practitioner is unavailable to provide the visit services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.;
- The participating 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 participating 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 participating Practitioner or group practice acting on his/her behalf must notify BCBST of the date he/she returns to work via email to PNS_GM@BCBST.com.
- The participating Practitioner, or group practice acting on his behalf, has ascertained that the "locum tenens" is qualified by training and experience to temporarily maintain the participating Practitioners' practice;
- The participating 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 participating Practitioner for purposes of this policy.
- Services may not be provided by the locum tenens for a continuous period of more than ninety (90) days. Any claims for the date of service after the 90th day will be processed as out of network.
- The participating Practitioner, or group practice acting on his behalf, must keep on file a record of each service provided by the locum tenens 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 participating Practitioner who has left group practice, claims should be submitted with the 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 CMS-1450 claim form follow:

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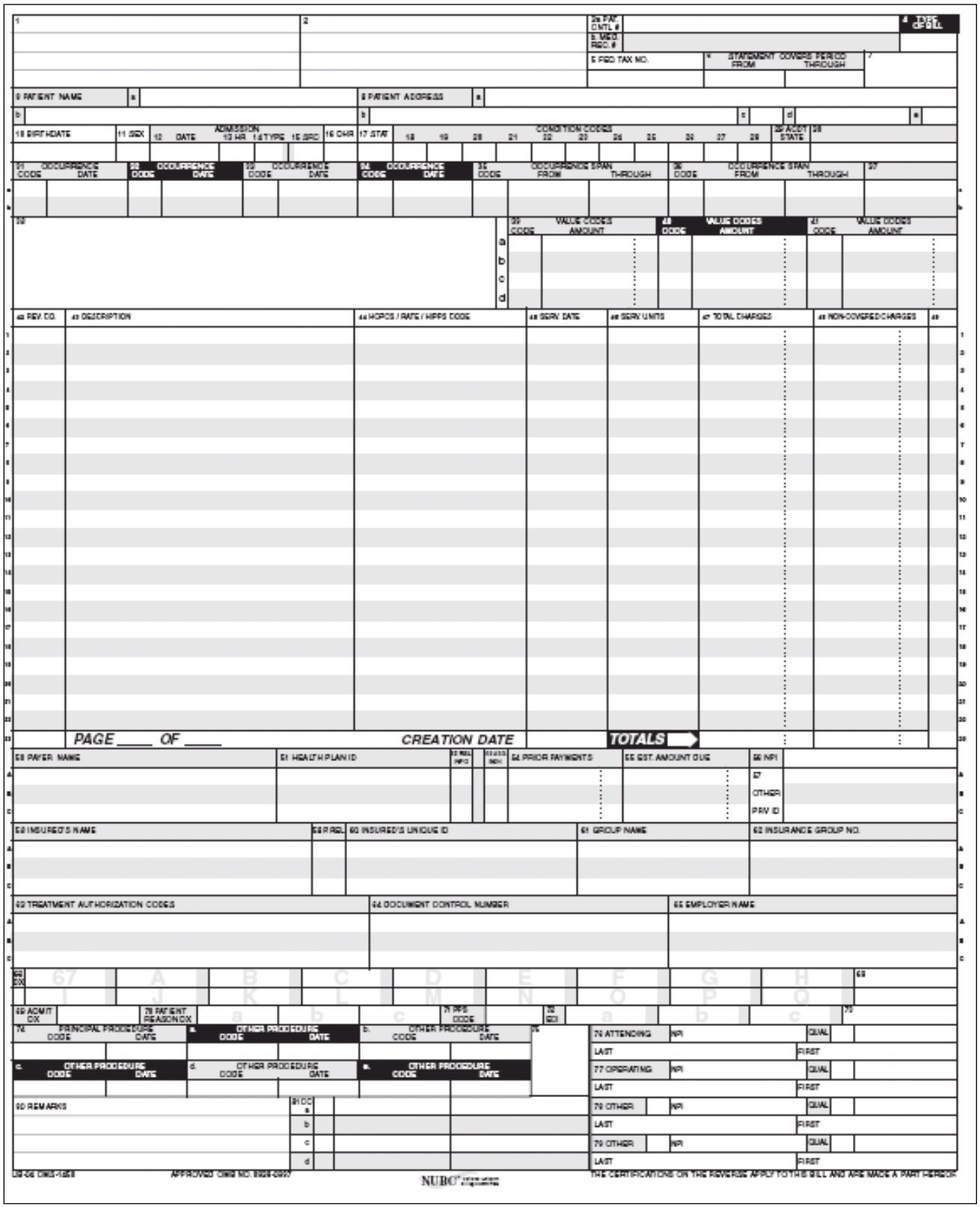
CMS-1450



CMS-1450 (UB-04) Form Locators and Field Description:

Form Locator 1	Provider Name, Address, Telephone Number***
Form Locator 2	Pay-to Name, Address, City, State, and ID
Form Locator 3	3a>Patient Control Number*** 3b>Medical Record Number***
Form Locator 4	Type of Bill***
Form Locator 5	Federal Tax Number***
Form Locator 6	Statement Covers Period***
Form Locator 7	Unlabeled Field
Form Locator 8	8a>Patient Name-ID 8b>Patient Name***
Form Locator 9	9a>Patient Address-Street 9b>Patient Address-Other 9b>Patient Address-City 9c>Patient Address-State 9d>Patient Address-Zip 9e>Patient Address-Country Code***
Form Locator 10	Patient Birthdate***
Form Locator 11	Patient Sex***
Form Locator 12	Admission Date*** (Inpatient)
Form Locator 13	Admission Hour*** (except for Bill Type 02X)
Form Locator 14	Type of Admission/Visit***
Form Locator 15	Source of Admission***
Form Locator 16	Discharge Hour*** (final inpatient claim only)
Form Locator 17	Patient Discharge Status***
Form Locator 18	Condition Codes
Form Locator 19	Condition Codes
Form Locator 20	Condition Codes
Form Locator 21	Condition Codes
Form Locator 22	Condition Codes
Form Locator 23	Condition Codes
Form Locator 24-28	Condition Codes
Form Locator 29	Accident State
Form Locator 30	Unlabeled Field
Form Locator 31	a-b Occurrence Code/Date
Form Locator 32-34	a-b Occurrence Codes and Dates
Form Locator 35	a-b Occurrence Span Code/From//Through
Form Locator 36	a-b Occurrence Span Code/From/Through
Form Locator 37	a-b Unlabeled Fields
Form Locator 38	1-5 Responsible Party Name/Address
Form Locator 39	a-d Value Code-Code
Form Locator 39	a-d Value Code-Amount
Form Locator 40	a-d Value Code-Code

Form Locator 40	a-d Value Code –Amount
Form Locator 41	a-d Value Code-Code
Form Locator 41	a-d lines Value Code-Amount
Form Locator 42	Revenue Code***
Form Locator 43	1-22 Revenue Code Description***
Form Locator 43-44	Line 23 Page_of_Creation_Date
Form Locator 44	HCPCS/Rates/HIPPS/Rate Codes***
Form Locator 45	1-22 Service Date
Form Locator 45	Line 23 Creation Date
Form Locator 46	Units of Service***
Form Locator 47	Total Charges***
Form Locator 48	Non-Covered Charges
Form Locator 49	Unlabeled Field
Form Locator 50	Payer Identification***
Form Locator 51	Health Plan ID

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:

- Authorization is required on all inpatient hospital stays except for maternity cases and when Medicare is the primary insurer.
- For NICU admissions, facilities may choose to submit authorization requests under the mother's member ID or as soon as the baby is assigned a member ID.
- 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, procedure codes, 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 Process 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 Tennessee Member liability.

The formula for this payment is:

Inlier payment = (Base Rate x Relative Weight) - Member Liability

The Member's liability will be co-insurance only. These amounts represent the portion of the payment, which is the Member's responsibility based upon the BlueCare Tennessee Benefit Agreement.

Hospitals are allowed to separately bill for and collect Member 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, surgical procedures, diagnostic tests, and other treatments will be subject to BlueCare Tennessee's retroactive audit. BlueCare Tennessee generally considers an inpatient stay to cross at least two days. If the member was discharged prior to 48 hours, claims should be billed as outpatient. If an inpatient claim has been denied, resubmit as corrected claims for the outpatient services provided during the hospital stay.

Inpatient stays extending beyond 48 hours will continue to be subject to retrospective medical necessity review. Where BlueCare Tennessee determines that the services could have safely been performed at a less costly setting with no jeopardy to the patient, a recovery will be processed in accordance with audit recovery procedures.

- **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 listed in the Provider Agreement. **Please Note:** If the Provider Agreement does not contain any discharge status codes, the claims are identified by the following codes filed on the claim as follows: 02, 05, 07, 66, 70 or 82-95.

  The facility from which the Member is ultimately discharged receives the full DRG payment rate. Discharge status 07 (Left against medical advice or discontinued care) will be reimbursed using the same methodology as a transfer.

  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**

  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 listed below under the heading of MAY be authorized. Readmissions listed under the heading of MAY NOT be authorized represent examples and not the entire list of conditions that are subject to this policy.

  Claims for patients at either a DRG or Per Diem facility that are re-admitted for a condition other than those specified as exceptions to 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:

  - Acute myocardial infarction (AMI);
  - Pneumonia;
  - Respiratory admissions, e.g., COPD;
  - Complications from surgical procedures; or
  - Heart failure

  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 under 21 years 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 (Discharge Status Code 07)**

  Refer to Transfer Payment Policy above for reimbursement guidelines.

- **Exclusions**

  The following conditions and/or treatments are specifically excluded from DRG Reimbursement BlueCare/TennCare*Select* Attachment reference:

  a. Mental disease and disorders (MDC 19)

b. Alcohol and drug use (MDC 20)
c. Rehabilitation

- **BlueCare Tennessee Member Liability**

  Network Providers may bill and collect from Member 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 Tennessee 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 or Per Diem 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 or Per Diem 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 or Per Diem 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 or Per Diem 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 TennCare*Select* Attachment.

- **Inpatient Billing Requirements**

  - Submit Claims for services provided to BlueCare Tennessee 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 Tennessee 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 Tennessee Claims Service Center
1 Cameron Hill Cr, Suite 0002
Chattanooga, TN 37402-0002

2. Post-Partum Voluntary Long Acting Reversible Contraceptive Reimbursement (PP VLARC)

Beginning November 1, 2017, BlueCare Tennessee began reimbursing Providers for voluntary long-acting reversible contraceptives (VLARC) as separate items. Charges for the VLARC 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 December 2017. 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/.

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 Tennessee 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 Tennessee 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 Tennessee will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the never event. BlueCare Tennessee 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 .

BlueCare Tennessee 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 Tennessee will follow CMS guidelines for the billing of Never Events. In the instance that the "Never Event" has not been reported, BlueCare Tennessee will use any means available to determine if any charges filed with BlueCare Tennessee 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 Tennessee reserves the right to re-coup the reimbursement as necessary. BlueCare Tennessee will require all participating acute care hospitals to hold Members harmless for any services related to Never Events in any clinical setting.

BlueCare Tennessee 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 the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the *OPTUM Uniform Billing (UB*) Editor. 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):

Order	Description
1st	Current Year Medicare RBRVS fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.
2nd	Current Year Medicare RBRVS fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.

Order	Description
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 (Calculated using the CMS formula) 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 Tennessee 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 Tennessee 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 <u>EXCLUDING</u> 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 Tennessee 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 Tennessee 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.

Acute Care Outpatient Surgery

Minor Surgery (RC 0361) services are outpatient surgery codes that according to BlueCare's medical staff could be performed in a physician office setting. This RC billed with no procedure code will allow $0.00. If a minor surgery is performed in conjunction with an all-inclusive service, the minor surgery will bundle to the all-

inclusive service. If an all-inclusive service is not billed on a claim, then the line item will allow $0.00. BlueCare will not make any payment for the supplies or room charges when these procedures are performed in the facility unless RC 0361 is billed with a procedure code listed in Exhibit 3 - Schedule B with a maximum allowable greater than $0.00.

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.

Note: Refer to the BlueCare Amendment to the BlueCross BlueShield of Tennessee Institution Agreement, Exhibit B-IV for additional Information.

Submit claims to:

BlueCare Tennessee Service Center
1 Cameron Hill Circle, Ste 000
Chattanooga, TN 37402-0002

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.

0250 — 0259	Pharmacy
0270 — 0279	Medical Surgical supplies and devices
0710 — 0719	Recovery Room
0720 — 0722	Labor Room / Delivery
0729	Other Labor Room / Delivery
0760 or 0762	Treatment or Observation Room

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 and CoverKids will allow up to 48 hours for the Observation Services if Medically Necessary and Medically Appropriate. Hours billed in excess of 48 hours will not be allowed. (36 hours prior to 8/1/2021)

Revenue Code (RC)	Type of Service	HCPCS/CPT® Code	Allowed
0729	Other Labor Room/Delivery	N/A	Allowed at an hourly rate per contract not to exceed 48 hours (36 hours prior to 8/1/2021)
0762	Observation Room	N/A	Allowed at an hourly rate per contract not to exceed 48 hours (36 hours prior to 8/1/2021)
0769	Other Specialty Services	N/A	Allowed at an hourly rate per contract not to exceed 36 hours (36 hours prior to 8/1/2021)

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, 0452, or 0459 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.)

  Note: Clinic Visits are incidental services and not reimbursed separately unless otherwise stated in the provider's contract.

12. Newborn (Applies to CoverKids effective DOS 1/1/2021)

- Reimbursement method: DRG
- TennCare requires that each BlueCare and TennCare*Select* 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 Tennessee 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.

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.

Service	Condition Code FL 39-41	Revenue Code FL 42	Unit/ Frequency FL 46	Composite Rate FL 47
Hemodialysis – Method I or II Composite Rate	71, 73, 74, 76, or 84	082X	Per Visit	Composite Rate
Peritoneal Dialysis - Method I or II Composite Rate	71, 73, 74, 76, or 84	083X	Per Visit	Composite Rate
CAPD - Method I or II Composite Rate	73, 74, or 84	084X	Per Visit	Composite Rate
CCPD - Method I or II Composite Rate	73, 74, or 84	085X	Per Visit	Composite Rate

- **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.

Fee Schedules					
Revenue Code FL 42	**Service**	**Description**	**HCPCS/ Rates FL 44**	**Service/ Units FL 46**	**Total Charges FL 47**
0300	Laboratory	General	Fee Schedule	Appropriate	Charges
0301	Laboratory	Chemistry	Fee Schedule	Appropriate	Charges
0302	Laboratory	Immunology	Fee Schedule	Appropriate	Charges
0303	Laboratory	Renal Patient (Home)	Fee Schedule	Appropriate	Charges
0304	Laboratory	Non-routine Dialysis	Fee Schedule	Appropriate	Charges
0305	Laboratory	Hematology	Fee Schedule	Appropriate	Charges
0306	Laboratory	Bacteriology and Microbiology	Fee Schedule	Appropriate	Charges
0307	Laboratory	Urology	Fee Schedule	Appropriate	Charges
0309	Laboratory	Other	Fee Schedule	Appropriate	Charges
0310	Laboratory Pathological	General	Fee Schedule	Appropriate	Charges
0311	Laboratory Pathological	Cytology	Fee Schedule	Appropriate	Charges
0312	Laboratory Pathological	Histology	Fee Schedule	Appropriate	Charges
0314	Laboratory Pathological	Biopsy	Fee Schedule	Appropriate	Charges
0319	Laboratory Pathological	Other	Fee Schedule	Appropriate	Charges
0390	Blood Storage and Processing	General	Fee Schedule	Appropriate	Charges
0391	Blood Storage and Processing	Blood administration	Fee Schedule	Appropriate	Charges
0399	Blood Storage and Processing	Other blood storage and processing	Fee Schedule	Appropriate	Charges
0636	Drugs Requiring Specific Identification	Drugs Requiring Detailed Coding	Fee Schedule	Appropriate	Charges
0380	Blood	General	Fee Schedule	Appropriate	Charges
0381	Blood	Packed Red Cells	Fee Schedule	Appropriate	Charges
0382	Blood	Whole Blood	Fee Schedule	Appropriate	Charges
0383	Blood	Plasma	Fee Schedule	Appropriate	Charges
0384	Blood	Platelets	Fee Schedule	Appropriate	Charges
0385	Blood	Leukocytes	Fee Schedule	Appropriate	Charges
0386	Blood	Other Components	Fee Schedule	Appropriate	Charges
0387	Blood	Other Derivatives	Fee Schedule	Appropriate	Charges
0389	Blood	Other	Fee Schedule	Appropriate	Charges

- **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)		
Revenue Code	**Service Description**	**Pricing Comment**
0800	Inpatient Renal Dialysis General	$0.00 Not allowed under the contract
0801	Inpatient Renal Dialysis Hemodialysis	$0.00 Not allowed under the contract
0802	Inpatient Renal Dialysis Peritoneal (Non-CAPD)	$0.00 Not allowed under the contract
0803	Inpatient Renal Dialysis Continuous Ambulatory Peritoneal Dialysis (CAPD)	$0.00 Not allowed under the contract
0804	Inpatient Renal Dialysis Continuous Cycling Peritoneal Dialysis (CCPD)	$0.00 Not allowed under the contract
0809	Inpatient Renal Dialysis Other	$0.00 Not allowed under the contract
0820	Hemodialysis General	$0.00 Not allowed under contract
0824	Hemodialysis Maintenance/100%	$0.00 Incidental to the composite rate
0825	Hemodialysis Support Services	$0.00 Incidental to the composite rate
0829	Hemodialysis Other	$0.00 Incidental to the composite rate
0830	Peritoneal Dialysis General	$0.00 Not allowed under contract
0834	Peritoneal Dialysis Maintenance/100%	$0.00 Incidental to the composite rate
0835	Peritoneal Dialysis Support Services	$0.00 Incidental to the composite rate
0839	Peritoneal Dialysis Other	$0.00 Incidental to the composite rate
0840	(CAPD) General	$0.00 Not allowed under contract
0844	(CAPD) Maintenance/100%	$0.00 Incidental to the composite rate
0845	(CAPD) Support Services	$0.00 Incidental to the composite rate
0849	(CAPD) Other	$0.00 Incidental to the composite rate
0850	(CCPD) General	$0.00 Not allowed under contract
0854	(CCPD) Maintenance/100%	$0.00 Incidental to the composite rate
0855	(CCPD) Support Services	$0.00 Incidental to the composite rate
0859	(CCPD) Other	$0.00 Incidental to the composite rate
086X	Reserved	$0.00 Invalid Revenue Code
087X	Reserved	$0.00 Invalid Revenue Code
0880	Miscellaneous Dialysis General	$0.00 Not allowed under the contract
0881	Miscellaneous Dialysis Ultrafiltration	$0.00 Not allowed under the contract
0882	Miscellaneous Dialysis Home Dialysis Aid Visit	$0.00 Not allowed under the contract
0889	Miscellaneous Dialysis Other Misc. Dialysis	$0.00 Not allowed under the contract
025X	Pharmacy	$0.00 Incidental to the composite rate
0270	Medical Surgical Supplies and Devices General	$0.00 Incidental to the composite rate
029X	DME	$0.00 Not allowed under the contract

16. Hospice

All Hospice services 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 for nursing home residents without Medicare benefits is to be 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:

Revenue Code	Description ~ Service
0651	Routine Home Care (RHC) – less than 8 hours of care (1 day =1 unit)
0652	Continuous Home Care Full Rate = 24 hours of care based on an hourly rate. A separate line item must be billed for each date of service using the appropriate number of units in the unit field. (Billed in 15 minute increments)
0653	Invalid
0654	Invalid
0658	Inpatient Room & Board for nursing home residents (a separate claim form must be filed for all other services rendered, including Hospice services.)
0655	Inpatient Respite Care – Family member or other caregiver requiring a short relief period (limited to 5 consecutive days)
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 Tennessee claims for Inpatient Room and Board for nursing home residents using Revenue Code 0658 instead of Revenue Code 0654. The hospice indicator number for inpatient claims filed with Revenue Code 0658 is a 7-digit number beginning with "Q", "744", or "044" assigned by the state. It is used to determine the facility allowable and should be billed in Block 80 of the CMS-1450 claim form with no additional information in that Block. 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 Tennessee 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 Tennessee 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, unless otherwise stated in the Providers contract:

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Visits	Physical Therapy Occupational Therapy Speech Therapy Medical Social Services	0421 0431 0441 0561	Not required Not required Not required Not required	1 unit per visit 1 unit per visit 1 unit per visit 1 unit per visit
Home Health Intermittent Visits	Skilled Nursing Visit (RN) Skilled Nursing Visit (LPN) Home Health Aid Visit	0551 0551 0571	G0299 G0300 G0156	1 unit/15 minute 1 unit/15 minute 1 unit/15 minute
Home Health Extended Visits	Skilled Nursing Hour (RN) Skilled Nursing Hour (LPN) Home Health Aide Hour	0552 0552 0572	S9123 S9124 S9122	1 unit/1 hour 1 unit/1 hour 1 unit/1 hour
Private Duty	Private Duty Nursing	0589	T1000	1 unit/15 minute

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:

Modifier	Description
UN	Two patients served
UP	Three patients served
UQ	Four patients served
UR	Five patients served
US	Six or more patients served

Electronic Visit Verification (EVV)

Effective Jan. 1, 2023, all agencies that provide home health services to patients enrolled in a Medicaid plan must have an electronic visit verification (EVV) system in place for staff use to be in compliance with the 21st Century Cures Act. At a minimum, EVV systems should track the:

- Type of service performed
- Individual receiving services
- Date of service
- Location of service
- Individual providing the service
- Time the service begins and ends

Home health agencies can use the EVV vendor of their choice to capture the required data. The EVV vendor used by the home health agency must be connected to the MCO's aggregator in order to capture the visit information.

For more information or for any questions, please contact your Provider Network Manager. You can also access additional resources about EVV by visiting bluecare.bcbst.com/providers/tools-resources and choose **Resources for Home Health Providers.**

Please note that beginning July 1, 2023, we'll deny claims for home health services if an agency isn't using an electronic visit verification (EVV) system. As a reminder, all home health agencies treating members enrolled in a Medicaid plan must use an EVV system to track that member visits occurred as scheduled.

Please visit the bcbst.com website at https://bluecare.bcbst.com/providers/tools-resources/general/home-health to view all provider home health resources.

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:

A2014	A4320	A4352	A4368	A4384	A4400	A4417	A4432	A4626	A5081	A6531	A7521	T4527	T4534
A2015	A4321	A4353	A4369	A4385	A4404	A4418	A4433	A5051	A5082	A6532	A7522	T4528	A9272
A2016	A4326	A4354	A4371	A4387	A4405	A4419	A4434	A5052	A5083	A7045	A7523	T4529	
A2017	A4328	A4355	A4372	A4388	A4406	A4420	A4435	A5053	A5093	A7047	A7045	T4530	
A2018	A4330	A4356	A4373	A4389	A4407	A4422	A4436	A5054	A5102	A7501	A7524	T4531	
A4212	A4331	A4357	A4375	A4390	A4408	A4423	A4437	A5055	A5105	A7502	A7526	T4532	
A4248	A4333	A4358	A4376	A4391	A4409	A4424	A4455	A5056	A5112	A7503	A7527	T4533	
A4310	A4334	A4360	A4377	A4392	A4410	A4425	A4456	A5057	A5113	A7504	S8210	T4534	
A4311	A4338	A4361	A4378	A4393	A4411	A4426	A4459	A5061	A5114	A7505	T4521	T4535	
A4312	A4340	A4362	A4379	A4394	A4412	A4427	A4461	A5062	A5120	A7506	T4522	T4537	
A4313	A4344	A4363	A4380	A4395	A4413	A4428	A4463	A5063	A5121	A7507	T4523	T4540	
A4314	A4346	A4364	A4381	A4396	A4414	A4429	A4481	A5071	A5122	A7508	T4524	T4541	
A4315	A4349	A4366	A4382	A4398	A4415	A4430	A4623	A5072	A5126	A7509	T4525	T4542	
A4316	A4351	A4367	A4383	A4399	A4416	A4431	A4625	A5073	A5131	A7520	T4526	T4543	

The following codes should be used when billing home health agency non-routine supplies with revenue code 0623:

A6010	A6205	A6221	A6237	A6252	A6407	A6451
A6011	A6206	A6222	A6238	A6253	A6410	A6452
A6021	A6207	A6223	A6239	A6254	A6412	A6453
A6022	A6208	A6224	A6240	A6255	A6441	A6454
A6023	A6209	A6228	A6241	A6256	A6442	A6455
A6024	A6210	A6229	A6242	A6258	A6443	A6456

A6154	A6211	A6230	A6243	A6259	A6444	A6457
A6196	A6212	A6231	A6244	A6261	A6445	A6545
A6197	A6213	A6232	A6245	A6262	A6446	A7040
A6198	A6214	A6233	A6246	A6266	A6447	A7041
A6199	A6215	A6234	A6247	A6402	A6448	A7048
A6203	A6219	A6235	A6248	A6403	A6449	
A6204	A6220	A6236	A6251	A6404	A6450	

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 32X. 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:

Description	Revenue Code	Procedure Code	Billing Unit
Home management of preterm labor	0559	S9208	1 unit per day
Home management of gestational hypertension	0559	S9211	1 unit per day
Home management of preeclampsia	0559	S9213	1 unit per day
Home management of gestational diabetes	0559	S9214	1 unit per day

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.
  - 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 antiemetics. 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:

Type of Bill (FL 4)	Revenue Code (FL 42)	Description (FL 43)
21X or 22X	0191	Level I – Skilled Care
21X or 22X	0192	Level II – Comprehensive Care
21X or 22X	0193	Level III – Complex Care

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.
- 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

Type of Bill	Type of Facility
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:

Revenue Code	Description
0270**	General Supplies
041X	Respiratory Therapy
042X	Physical Therapy
043X	Occupational Therapy
047X	Audiology
044X	Speech Therapy
0519	Wound Care/Clinic Visit
0623	Surgical Dressings

***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
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.

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.

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.

Note: The Division of TennCare has requested a maximum allowable be placed on implant codes L8509 and L8614 for facilities. Please refer to the Division of TennCare Budget Memo Guidelines located at the end of the *General Billing and Reimbursement Information* sub-section in this Section or for more information, view the Budget Reduction Memo on our website at https://bluecare.bcbst.com/providers/news-manuals.

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.

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:

Service Codes	Description
H2017/H2018	Psychiatric Rehabilitation (per diem is inclusive of all components except Supported Housing)
H2023/H2024	Supported Employment
H0036/H0037	Comprehensive Child and Family Treatment/ Continuous Treatment Team (CCFT/CTT)
S9482/T2025	Family Support Specialist Services

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 Tennessee assigned provider number and/or NPI.
- All claims must be submitted with the BlueCare Tennessee 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 Tennessee 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. Institutional Claim Billing and Reimbursement Guidelines changes for Providers contracted with BCT Base Fee Schedule Version 7 or later.

Note: If the service category guidelines are not indicated below, defer back to prior section of BCT PAM for the applicable reimbursement guidelines. (Ex: Screening Fee Reimbursement)

1. Outpatient Surgery

Providers must refer to their contract for applicable services. A published list of surgery CPT®/HCPCs codes and Revenue codes (RC) is provided when contracted. All services must be billed based on where services are rendered.

BCT may revise the information in the outpatient (OP) surgery grouper listing based on newly published and/or deleted codes and updated outpatient surgery information developed by CMS, which may be modified

by BCT to include procedures that are not maintained by CMS but are considered for reimbursement. Recalibration is based on the CMS OPPS weights effective annually on January 1. As the weights change, codes may be moved up or down in the grouper listing based on pre-established weight ranges for each grouping. The Outpatient Surgery Groupers will be subject to annual updates and recalibration to occur on April 1; provided, however, codes hitting the UL category may be reviewed and assigned throughout the year to the appropriate surgery grouper as evaluated by BCBST.

2. Minor Surgery

CPT®/HCPCS codes that are eligible for reimbursement and billed with Minor Surgery Revenue Code 0361 will reimburse from whatever grouper rate the CPT®/HCPCS code is assigned based on the Institutional Surgical Groupers 0-10 and UL indicated in the Provider's contract.

3. Acute Care Fee Schedules

There will be no revisions for the existing CPT®/HCPCS codes allowable reimbursement for the Acute Care Fee Schedules indicated below as they will remain static to the CMS year indicated in your contract. Refer to the **General Billing and Reimbursement Information Section F** for any new, deleted, or revised code update guidelines. A published list of HCPCS Codes and Revenue Codes is provided when contracted.

Laboratory

MRI/MRA/CT Scan

Radiology

Base Fee Schedule

4. Acute Care Emergency Room Services

Emergency room services for an emergency condition do not require prior authorization. However, if the Member is admitted to the hospital as inpatient from the emergency room, In-network Providers are responsible for contacting BCT within 24 hours or the next working day of the inpatient admission.

5. Reimbursement Policy and Billing Guidelines for the Separately Reimbursed Facility Drug Fee Schedule

To establish the codes that are added to the Separately Reimbursed Facility Drug Fee Schedule. BCT will utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCT will identify the eligible outpatient drug HCPCS/CPT® codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Separately Reimbursed Facility Drug Schedule aren't eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will be denied as procedure code required for RC.

In the circumstance that an inappropriate payment has occurred, BCT reserves the right to re-coup the reimbursement as necessary.

BCT shall reimburse acute care hospitals contracted for the Separately Reimbursed Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

SR Base Facility Drug Fee Schedule

Pricing Methodology	SR 1 Percentage of Base Allowed	SR 2 Percentage of Base Allowed
Average Sale Price (ASP)	108%	106%

Pricing Methodology	SR 1 Percentage of Base Allowed	SR 2 Percentage of Base Allowed
Wholesale Acquisition Cost (WAC)	100%	100%
Average Wholesale Price (AWP)	84%	84%

If facility is contracted with this schedule, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services filed on the CMS-1450 (UB-04 or successor) claim form.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/ CPT® code that could be used, BCT will reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to the schedule with a $0.00 allowable and “BR” or “UL” indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST’s policy for Unlisted, Miscellaneous, Non- specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCBST’s Policy “Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:

- Must be billed with a unit of one (1); and
- Requires submission of drug name; National Drug Code (NDC) in field 43, “Revenue Description/ IDE/ Medicaid Drug Rebate”, on the CMS-1450 Claim form; and dosage administered.

Note: Percentages and base allowable as set forth in the SR Facility Drug Fee Schedules are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges.

Exclusions for SR 1 & 2 Fee Schedules

Any items identified as over the counter or drugs not requiring a prescription, self-administered or oral medications, and medications not reimbursed separately by Medicare based on status indicator. Updates to these schedules will occur annually on April 1 for existing codes that have changed and now may or may not meet the above descriptive or revenue code criteria.

6. Reimbursement Policy and Billing Guidelines for the Tiered Facility Drug Fee Schedule

To establish the codes that are added to the Tiered Facility Drug Fee Schedule, we’ll utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCT will identify the eligible outpatient HCPCS/CPT® codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding; 0891, Special Processed Drugs – FDA Approved Cell Therapy; and 0892, Special Processed Drugs – FDA Approved Gene Therapy as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Tiered Facility Drug Fee Schedule are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will be denied as procedure code not contracted.

In the circumstance that an inappropriate payment has occurred, BCT reserves the right to re-coup the reimbursement as necessary.

BCT shall reimburse acute care hospitals contracted for the Tiered Facility Drug Fee Schedule for eligible outpatient therapeutic codes based on a percentage of the Average Sale Price (ASP), or in the absence of a

published ASP, Wholesale Acquisition Cost (WAC). In the absence of both ASP and WAC, Average Wholesale Proce (AWP) shall be used. The table below indicates the Base Drug Fee Schedule pricing for each of the above methodologies.

Tiered Facility Base Drug Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

- Tier 1 – Traditional
- Tier 2 – Biosimilars
- Tier 3 – Specialty Drugs
- Tier 4 – Ultra High Cost

If facility is contracted with this schedule, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services files on the CMS-1450 (UB-04 or successor) claim form.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/CPT® code that could be used, we'll reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to the schedule with a $0.00 allowable and "BR" or UL" indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCT's policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCT's Policy "Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:

- Must be billed with a unit of one; and
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/IDE/Medicaid Drug Rebate", on the CMS-1450 Claim form, and dosage administered.

NOTES: Percentages and base allowables as set forth in this Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges.

Any items identified as over the counter or drugs not requiring a prescription, self-administered and oral medications, and medications not reimbursed separately by Medicare based on status indicator have been excluded from this Facility Fee Schedule.

Updates to this schedule will occur annually on April 1 for existing codes that have changed and now may or may not meet the above descriptive or revenue code criteria. New codes will default to Tier 4 until the April 1 update at which time they will be placed in the appropriate Tier

7. Reimbursement Policy and Billing Guidelines for the Ultra High Cost Fee Schedule

To establish the codes that are added to the inpatient Ultra High Cost Fee Schedule, we'll utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCT will identify the eligible HCPCS/CPT® codes that are appropriate to be billed under RC(s) 0636, Drugs Requiring Detail Coding; 0891, Special Processed Drugs – FDA Approved Cell Therapy; and 0892, Special Processed Drugs – FDA Approved Gene Therapy as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

BCT will pay for inpatient drugs listed in the Ultra High Cost Fee Schedule, in accordance with the Reimbursement and Billing Guidelines for the Ultra High Cost Fee Schedule contained in this policy in addition to the Ultra High Cost Therapy Admission filed on the CMS-1450 (UB-04 or successor) claim form.

Drugs shown on the Ultra High Cost Fee Schedule and associated with Not Otherwise Classified ("NOC") or Unlisted/Miscellaneous/Non-Specific HCPCS Codes or with no established fee shown will be manually priced in accordance with BCBST's policy for Unlisted, Miscellaneous, Non-Specific and Not Otherwise Classified Procedures/Services, but may not be eligible for payment. Such drugs must be billed with a unit of one (1) and require submission of: (i) drug name; (ii) National Drug Code ("NDC") in field 43 "Revenue Description/IDE/Medicaid Drug Rebate" on the CMS-1450 claim form; and (iii) dosage administered. Failure to submit this information will result in delayed reimbursement.

Drug codes submitted for consideration, but not shown in the Ultra High Cost Fee Schedule are included in the Inpatient reimbursement and are not eligible for additional payment.

The Ultra Hight Cost Fee Schedule will be updated in accordance with BCT's Policy "Quarterly Reimbursement Changes."

Notwithstanding the DRG Payment Rate set forth in the Inpatient Payment Category Table for a covered Inpatient Stay, when Provider submits a claim for payment of a drug listed on the Ultra High Cost Fee Schedule, the Provider will be paid the Per Diem listed in the Inpatient Payment Category Table for the Ultra High Cost Therapy Admission and the applicable Payment Rate for the drug set forth on the Ultra High Cost Fee Schedule instead of the applicable DRG Payment Rate.

Ultra-High Cost Base Drug Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

8. Observation Services Billing and Reimbursement Guidelines

For Providers contracted with the BCT Base Fee Schedule Version 7 or later, Observation is a case rated service and will not be paid at an hourly rate. Please refer to the Provider's contract for specific reimbursement details.

9. All Other Outpatient Services:

The following RCs will be considered according to the All Other Outpatient Services section of the contract unless performed with an all-inclusive service.

Note: If any of the following RCs are on any other fee schedules, these guidelines do not apply.

Revenue Code	Type of Service
0240	All -Inclusive Ancillary-General
0241	All -Inclusive Ancillary-Basic
0242	All -Inclusive Ancillary-Comprehensive
0243	All -Inclusive Ancillary-Specialty
0249	All -Inclusive Ancillary-Other
0623	Surgical dressings

O. Dental Services Provided By Renaissance

(See Section XVIII. CoverKids in this Manual for covered dental services for CoverKids.)

Effective November 1, 2025, the Division of TennCare and Renaissance entered into an arrangement where Renaissance administers and manages dental services for all TennCare Members for all Managed Care Organizations. Administration changes include, but are not limited to:

- Renaissance distributes its own Dental Provider Directory.
- Renaissance handles all customer service.
- Renaissance processes all claims.

Note: Effective 1/1/2023, dental services are covered for all BlueCare/TennCare*Select* members.

Adult dental benefits are not applicable to members who have CoverKids. CoverKids children have dental benefits through age 18.

If you have any questions or need additional information, please call Renaissance Customer Service at 1-866-864-2526.

NOTE: Prior to November 1, 2025, DentaQuest was the Dental Benefits Provider. For claims prior to this date, please contact DentaQuest customer service at **1-866-864-2526**.

P. 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 Member 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.
- The first pair of cataract glasses and or contact lens/lenses following cataract surgery is covered for adults;

Code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal

Code	Description
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92370	Repair and refitting spectacles, except for aphakia
V2020, V2025	Frames
V2100-V2118, V2199	Lens - single vision
V2200-V2220, V2299	Lens - bifocals
V2300-V2320, V2399	Lens - trifocals

Vision benefits are provided for the following diagnoses or treatment when billed on a CMS-1500 claim form:

Ametropia	Hypertrophia	Strabismus	Exotropia
Astigmatism	Myopia	Error of Refraction	Amblyopia
Hypermetropia	Presbyopia	Esotropia	

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:

Code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
92370	Repair and refitting spectacles, except for aphakia
V2020, V2025	Frames
V2100-V2118, V2199	Lens - single vision
V2200-V2220, V2299	Lens - bifocals
V2300-V2320, V2399	Lens - trifocals

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.”

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	
Chalazion	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 Member, 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
- Block 33, Individual Provider's Name, billing address and BlueCare Individual Physician Number
- Block 32, Practice address, if different from billing address.
- Claim for the following codes must have documentation attached showing Medical Necessity: V2500, V2501, V2502, V2503, V2510, V2511, V2512, V2513, V2520, V2521, V2522, V2523, V2530, V2531, V2599

Q. OptumRX Program (See XVIII. CoverKids of this Manual)

TennCare's pharmacy program has a single Preferred Drug List (PDL) that is used statewide for all Members 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/managed-care-contractors/pharmacy-benefits-manager.html. The Automatic Exemption and Attestation 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.

Note: **Effective 8/1/25,** TennCare will no longer enforce the 5-prescription limit per month on prescription drugs and refills for adult TennCare enrollees. However, the 2-brand prescription limit per month will remain in effect.

Providers that feel they cannot prescribe a drug listed on the PDL are required to seek prior authorization in advance and 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 OptumRX Program will produce a report identifying the top one hundred prescribers whose prescriptions are frequently written for non-preferred drugs. The OptumRX Program will attempt to contact these prescribers and offer PDL assistance and education.

TennCare Pharmacy Contact Information (for provider use only)

Drug Prior Approval:

OptumRx Prescriber Prior Authorization:	1-866-434-5524
Fax:	1-866-434-5523

(Submit prior authorization requests only via fax or electronically through "Covermymeds" at https://professionals.optumrx.com/prior-authorization.html)

Pharmacy Billing Guidelines

Services included in the State of Tennessee Division of TennCare's OptumRX 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 OptumRX Program.

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 OptumRX Program 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 OptumRX. 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

For a list of covered diabetic supplies, refer to the Covered OTC List located on the OptumRx website at: https://www.optumrx.com/oe_tenncare/pharmacist

To order diabetic supplies, complete the *Prior Authorization Form for Diabetic Supplies* located on the OptumRX website at: https://professionals.optumrx.com/prior-authorization.html

- Fax the completed form to OptumRX 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.

1. United States Pharmacopeia: 2008-2009 USP Pharmacists' Pharmacopeia. 2nd ed.5th supplement. Chapter <797> Pharmaceutical Compounding-Sterile Preparations. Rockville, MD: United States Pharmacopeia Convention, April 21-24, 2010. Washington, DC
2. PCAB Standards. Pharmacy Compounding Accreditation Board. Washington, DC. Available at http://www.pcab.org Accessed November 20, 2012.

R. 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.

Mail to BlueCross BlueShield of Tennessee or BlueCare Tennessee
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, or directive from the Division of TennCare, 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:

EX Code	Description
AD4	Disallowed amount prior to Subrogation adjustment
ADX	Provider information changed- no interest
CO1	Secondary – other insurance
MSP	Payment was made on claim for a member with Medicare primary
YAI	Additional information received
YBE	Claim billed in error
YBI	Interim Bill
YCC	Deductible/Copay/Coin corrected
YCP	COB adjustment-paid primary
YCS	Payment secondary to other insurance
YDD	Duplicate- should have denied
YDP	Not Duplicate- should have paid

EX Code	Description
YEU	Eligibility Updated
YNI	Paid wrong benefit level
YSP	Eligible charge denied in error
YSD	Ineligible charge paid in error
YUM	Authorization updated
YWI	Claim paid on wrong ID or wrong patient

S. 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.

CAQH ProViewTM 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

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.

Note: Effective 12/2/21:

BlueCare Tennessee accepts electronic funds transfer (EFT) enrollment through Change Healthcare who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The Change Healthcare process facilitates compliance with CAQH Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

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 and https://bluecare.bcbst.com.

For more information regarding the EFT program process, or for assistance with Availity, please call eBusiness Service at 800-924-7141 and follow the prompts to eBusiness support or email eBusiness_service@bcbst.com.

Payer Enrollment Services is the name for the new Change Healthcare EFT and ERA enrollment tool. Phone: 800-956-5190 Monday through Friday, 8 a.m. to 5 p.m.(Central) Website: payerenrollservices.com

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VI. Primary Care Provider (PCP)

(Effective 1/1/21, CoverKids members will be assigned PCPs)

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, TennCare*Select*, and CoverKids 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 45 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 15 business days 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/TennCare*Select*/CoverKids Members must reflect local practice and be on the same basis as all other patients served by the Practitioner.

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VII. Member Policy

A. Introduction

BlueCare, TennCare*Select* and CoverKids 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, TennCare*Select* and CoverKids 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 Responsibilities in the BlueCare, TennCare*Select* or CoverKids Member handbooks).

Providers are not permitted to encourage or suggest, in any way, 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 Tennessee 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 with due consideration for their dignity and privacy.
- Receive services without discrimination due to disability, 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, including the right to refuse treatment.
- 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 90 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, 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.

- 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 TennCare Connect if there is a change in employment, address or dependents, and other insurance.
- 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, TennCare*Select* or CoverKids 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:

- Health information and education
- Health care counseling
- Telephone triage to assess health status in order to direct Members to the appropriate level of care
- Assistance in identifying and selecting a Primary Care Practitioner (PCP)
- Assistance in scheduling appointments or referrals to PCP or Specialist
- Assistance in arranging care in an alternative setting (if needed)
- Referral to appropriate care management program (if needed)

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 to the 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 Member's Practitioner or with the covering 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
- Reason for call
- Name of Treating Practitioner
- 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	Definition	Standard
Routine Adult Physical Examination	Routine exam of a patient who has no acute symptoms which includes Medically Necessary and Appropriate health screening and immunizations, if a covered benefit.	≤ 3 weeks
TennCare Kids	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 www.aap.org 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.	≤ 3 weeks
Prenatal Care	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 or third trimester	 ≤ 3 weeks ≤ 15 days
Urgent Care for Adult and Child	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.	≤ 48 hours
Emergency Care for Adult and Child	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	Immediate

Appointment Type	Definition	Standard
	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.	
Specialty Care for Adults and Children	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.)	≤ 30 days
General Optometry Services	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.	≤ 3 weeks
Wait Times	1.Office Wait Time (including lab and X-ray) 2.Member Telephone Call (during office hours): ➢ Urgent… ➢ Routine 3.Member Telephone Call (after office hours): ➢ Urgent. ➢ Routine	≤ 45 minutes ≤ 15 minutes 24 Hours ≤ 30 minutes ≤ 90 minutes

References:

Thomas, Clayton L. MD(ED.) 1993 *Tabor's Cyclopedic Medical Dictionary.* (Edition 17) Philadelphia: F.A. Davis Company.
American Medical Association. (1998) *Physicians Current Procedural Terminology.*
Brodsky, Karen L. (1996, October 21). EPSDT Creates Medicaid Managed Care Challenges. *Managed Medicare and Medicaid Perspectives.*
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 Tennessee 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
   - 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 for BlueCare and TennCare*Select*/Effective Jan. 1, 2021 for CoverKids

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. The following statement does not apply to CoverKids. Unless contraindicated, the BlueCare Tennessee Member may continue to receive services if the Member requests continuation of service benefits within ten (10) calendar days of the Notice and the services have been prescribed by a Provider. CoverKids does not have continuation of service benefits during the appeals process.

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 Tennessee at least two (2) calendar days before the reduction, termination, or suspension of these services. The Provider Initiated Notice (PIN) form is available at https://bluecare.bcbst.com/forms/Provider%20Forms/Provider_Initiated_Notice-Adverse_Action.pdf . Submission instructions are indicated on the PIN form. BlueCare Tennessee 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, TennCare*Select* and CoverKids Members. A copy of this template is found on the following pages of this Manual and on the TennCare website.

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.

Mail to: BlueCare Tennessee 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, TennCare*Selec*t or CoverKids 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 TennCare Member Medical Appeals 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 Member Medical Appeals.
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 Member Medical Appeals within fourteen (14) calendar days of the MCO receiving the appeal for standard appeals or within seventy-two (72) hours for expedited appeals.

    a. If the MCO reverses its original decision, the requested services are to be rendered.
    b. If the MCO affirms its original decision and TennCare Member Medical Appeals 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. The Member can cancel the hearing at any time if he/she so wishes.
    c. If the MCO affirms its original decision and the Division of TennCare reverses the decision, the requested services are to be rendered.
    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/tenncare-provider-news-notices-forms/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 Tennessee 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 Tennessee should be submitted to the following address:

TennCare Member Medical Appeals
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 Tennessee patients*****.** If you need additional medical appeal forms, call the TennCare Member Medical Appeals 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 TennCare Connect 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 BlueCare Tennessee Members in obtaining complaint forms and MCO contact information.

All complaints alleging discrimination on the part of a Provider should be reported to BlueCare Tennessee at the numbers listed below. Members requiring assistance in filing a complaint should be referred to BlueCare Tennessee at the appropriate number listed below:

BlueCare	**TennCare*Select***	**CoverKids**
Member Services 1-800-468-9698	Member Services 1-800-263-5479	Member Services 1-800-325-8386
Provider Services 1-800-468-9736	Provider Services 1-800-276-1978	Provider Services 1-800-924-7141

Complaint forms are available in English, Spanish, and Arabic and can be obtained using the following links:

https://bluecare.bcbst.com/forms/Member-Handbooks/TennCare%20Discrimination%20Complaint%20Form.PDF

https://bluecare.bcbst.com/forms/Member-Handbooks/TennCare%20Discrimination%20Complaint%20Form_Spanish.PDF

https://bluecare.bcbst.com/forms/Member-Handbooks/TennCare-Discrimination-Complaint-Form-Arabic.pdf

Mail completed forms to:

TennCare, Office of Civil Rights Compliance
310 Great Circle Rd., Floor 3W
Nashville, TN 37243
1-855-857-1673 (TRS 711)
e-mail: HCFA.fairtreatment@tn.gov

As an alternative to mailing the complaint form, the Division of TennCare has launched a real-time, online non-discrimination complaint form in English, Spanish, and Arabic available at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

F. Financial Responsibility for the Cost of Services

If a BlueCare Tennessee Network Provider renders a service which is non-covered under the TennCare or CoverKids 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 a 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 or CoverKids 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 1200-13-13-.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.

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VIII. Utilization Management Program

A. Program Overview

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

Our Utilization Management (UM) Program is intended to assure the provision of appropriate health care to all BlueCare, TennCare*Select*, 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, TennCare*Select*, 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, TennCare*Select*, CHOICES, and ECF CHOICES cover medically necessary health care 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 member'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 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;
3. safe and effective;
4. not experimental or investigational; 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, TennCare*Select*, 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 member'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 the prior authorization process. Information on this process and the specific requirements are listed in detail below.

Note: If BlueCare is secondary to Medicare coverage, you should request prior authorization with the primary insurer first. Items or services that are covered by Medicare are not covered by TennCare. If the service is covered by Medicare, an authorization does not need to be requested from BlueCare.

B. How to Submit Prior Authorization Requests

Prior Authorization requests can be submitted in three ways:

1. Website

To access e-Health Services, click on the Availity section on the company websites, www.bcbst.com or http://bluecare.bcbst.com. This service is available 24 hours-a-day, seven-days-a-week for all registered providers. If you have 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.

This service allows you to submit requests and clinical updates to BlueCare Tennessee online in a real-time Web-secured environment. If the 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: Requests cannot be submitted via e-Health Services® Web Submission unless submitted with the member's personal identification number.

Note: For NICU admissions, facilities may choose to submit authorization requests under the mother's member ID or as soon as the baby is assigned a member ID. We've made updates to the Inpatient Confinement Form in Availity to allow backdating of requests for babies receiving NICU care. This will allow providers to submit requests in Availity once the baby has their own ID and backdate the request to the baby's date of birth. NICU authorization requests aren't subject to utilization management timely submission standards. Providers won't be issued a denial for non-compliance.

2. Phone

Prior authorization 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
***Select*Community**	1-800-292-8196

3. Facsimile

Prior Authorizations requests may be faxed to:

Medical

BlueCare or TennCare*Select*	1-800-292-5311
SNF/LTAC/Inpatient Rehab	1-423-591-9398
CHOICES/ECF CHOICES	1-800-357-0453
***Select*Community**	1-888-255-9175

Behavioral Health

BlueCare

East, Middle, West Grand Region	1-800-292-5311
Provider Initiated Notice	1-800-859-2922
TennCare*Select* (Statewide)	1-800-292-5311
Provider Initiated Notice (Statewide)	1-800-859-2922

***Note**: For a more streamlined process, Provider Initiated Notices can be submitted through Availity.*

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 submit the form electronically through Availity. If Availity is not available, you can also use the missed visit form located on the provider portal on the BlueCare website at 508C Home Health Missed Visit Form (bcbst.com)

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, TennCare*Select*, BlueCare Plus CHOICES, or CHOICES/ECF CHOICES at the appropriate number below:

BlueCare

Phone: 1-888-423-0131 Fax: 1-888-744-7587

TennCare*Select*

Phone: 1-800-711-4104 Fax: 1-888-744-7587

BlueCare Plus CHOICES

Phone: 1-866-789-6314 Fax: 1-866-325-6698

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.

Type of Service	Contact	Submit via:
• Skilled Nursing Facilities (SNF)/Rehab/Long Term Acute Care (LTAC)	BlueCare Tennessee	Web/Fax
• NICU admissions, updates, and concurrent reviews • Transplant Requests •Out-of-Network Services • Diagnostic Testing/Labs • Outpatient Procedures • Home Infusion Therapies • Inpatient Services • Behavioral Health Requests • Durable Medical Equipment • Home Health and Private Duty Nursing Services	BlueCare Tennessee	Web/Phone/Fax
• Maternity Care Management Notification	BlueCare Tennessee	Web
• Special Kids	BlueCare Tennessee	Fax
• Specialty Pharmacy Medications	BlueCare Tennessee	Web/Phone

C. Services Requiring Prior Authorization

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

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, 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, TennCare*Select*, CHOICES, or ECF CHOICES member receiving services outside the BlueCare, TennCare*Select*, 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.

➢ Hospice Services

Effective 4/1/2021, prior authorization is no longer required for the provision of hospice services.

➢ Transplant Services

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 a transplant authorization, call BlueCare Tennessee at 1-888-423-0131.

All organ/tissue transplants require **prior authorization**. It is critically important, to both the provider and member, that BlueCare Tennessee be contacted as soon as the member has completed a transplant evaluation and practitioner has deemed him/her as an appropriate candidate to be listed for transplant.

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

D. Outpatient Services Requiring Prior Authorization

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

The following outpatient services/procedures require prior authorization

- Autonomic Nervous System Testing
- Implantable Pain Pumps/Devices
- Joint Replacements and Spinal Procedures
- Orthognathic Surgery
- Proton Beam Therapy for age 21 years and older
- Radiofrequency Ablation/Facet Neurotomy
- Services performed by a plastic specialist, including but not limited to:
  - Abdominoplasty/Panniculectomy
  - Blepharoplasty
  - Breast Reduction
  - Reconstructive Repair Pectus Excavatum
  - Vein Ligation
- All Bariatric Surgeries – Submit requests on the Bariatric Surgery Authorization Request form located on the BlueCare Tennessee website at https://bluecare.bcbst.com/providers/forms.html.
- Acupuncture services are non-covered for all ages unless determined to be a cost-effective alternative.
- Diagnostic Testing/Laboratory Services – Select high cost lab testing codes require prior authorization. A full listing of the laboratory testing codes requiring prior authorization can be viewed online at: https://bluecare.bcbst.com/forms/Provider%20Forms/High_Cost_Lab_Prior_Authorization_List.pdf

Note: Prior Authorization is not required for TennCare Kids screenings when performed by a participating provider.

E. Specialty Pharmacy Prior Authorization Requirements

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

Certain high-risk/high-cost specialty pharmacy drugs administered by a provider in any setting other than inpatient require prior authorization for all lines of business.

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 search for a drug from the manual at https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.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. All drug claims should be submitted with the specific HCPCS code, supporting diagnosis codes and a valid NDC number 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

A complete listing of BlueCare specialty pharmacy medications can be viewed online at Provider-Administered Specialty Pharmacy Products (bcbst.com). Note: Some specialty pharmacy medications may require an associated inpatient hospital stay or outpatient procedure(s) to prepare and/or administer the medication (example: Chimeric antigen receptor T-cell (CAR-T) therapy). If an inpatient stay or outpatient procedure is needed, please fax authorization requests to BlueCare Utilization Management (UM) at **1-800-292-5311** or call **1-888-423-0131**. Select **option 9** to be transferred to the UM team.

➢ 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

HIT providers should continue to file claims with OptumRX when **only** billing for drugs and biologicals when no infusion services are provided. In these cases, HIT providers should adhere to OptumRX prior authorization requirements. Drugs, which cannot be self-administered, should be billed as a medical benefit by the administering provider.

F. Advanced Imaging Prior Authorization Requirements

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

Advanced imaging services include:

- CT
- PET
- MRI
- MRA
- Cardiac Imaging:
  - MPI-SPECT (Myocardial Perfusion Imaging)
  - Multigated Acquisition (MUGA) Scan

For BlueCare members, submit prior authorization requests using the Availity portal or by phone.

For TennCare*Select* members, no authorization is required for in-network providers. A complete listing of advanced imaging codes requiring prior authorization can be found on the BlueCare website at BlueCross BlueShield of Tennessee: Prior Authorization List (PAL) Codes Under Management (High Tech Imaging) – Payer Information

G. Durable Medical Equipment (DME), Orthotic and Prosthetic (O&P), Medical Supply Prior Authorization Requirements

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

Durable Medical Equipment (DME) means equipment that can withstand repeated use, can be removable, 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. 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 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:

1. are medically necessary for the continuous care of a member
2. 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
3. are solely for the use of that member and not for other nursing facility residents

As of March 6, 2026, the DME network transitioned to CareCentrix. HIT and O&P services are excluded from this transition. Providers may contact CareCentrix via the Call Center at 1-833-715-7767.

Prior Authorization is required on all DME and O&P provided by a DME/O&P provider with a cost of more than $500 per unit (with some exceptions as noted below).

DME codes and supplies that do require prior authorization (regardless of cost) are listed below:

- Exclusions specified by TennCare (per TennCare Rules)
- Miscellaneous DME codes
- All hospital beds, mattresses, and accessories codes
- Prosthetics and accessories Mastectomy prosthetic codes don't require authorization due to Tennessee Code Ann. § 56-7-2507)
- Wheelchairs and accessories
- All repairs and replacements (with the exception of CRT repairs)
- Labor charges

- Incontinence products quantity over 200 (quantities over 800 for (A4335) wipes)
- All enteral and oral formula [does not include Total Parenteral Nutrition (TPN)]
- Equipment rentals (This exception does not include the rental of apnea monitors, bedside commodes, humidifiers, phototherapy (Bili-lights), breast pumps, pulse oximeters and nebulizers)
- OON providers: Requests from providers with an out of network status or pay as par status requires prior authorization.

DME codes and supplies that do not require prior authorization (regardless of cost) are listed below:

- Surgical Codes should be billed with the surgical procedure, if a DME item is used within the procedure prior authorization is not required for the DME item. Please refer to the Outpatient (OP) prior authorization list for the surgical procedure.
- No authorization is required for Bath/Shower Equipment/Supplies
- No authorization is required for Upper Extremity Orthotics
- No authorization is required for all Diabetic equipment/supplies (including all Continuous Glucose Monitors (CGM) and Insulin pumps)
- No authorization is required for Ankle Foot Orthotics (AFO)
- No authorization is required for compression garments/stockings
- No authorization is required for hearing aids, vision and cochlear implants for under 21 years of age for BlueCare/TennCare*Select* or under 19 years of age for CoverKids (except for V2025, V2762, V2781-these require authorization)
- No authorization is required for supplies (examples are wound, trach, foley, ostomy supplies, etc.)
- CRT Repairs

Complex Rehab Technology (CRT)

For Complex Rehabilitation Technology, all codes/line items to be billed must be provided to pre-review for billable codes and provide coverage determinations for services. For DME to be reviewed as CRT you must complete the CRT DME Authorization Form with the required information. Forms are located on BCBST.com in the provider section. Forms | Providers | BlueCare Tennessee (bcbst.com)

Prior authorization isn't required for repairs of such technology or equipment unless:

- The repairs are covered under a manufacturer's warranty;
- The cost of the repairs exceeds the cost to replace the CRT or manual wheelchair; OR
- The CRT or manual wheelchair in need of repair is subject to replacement because the age of the CRT or manual wheelchair exceeds, or is within one year of the expiration of, the recommended lifespan of the CRT or manual wheelchair.

The Tennessee General Assembly recently passed legislation with new coverage guidelines for the repair of Complex Rehabilitation Technology (CRT), including manual and power wheelchairs. These guidelines take effect July 1, 2024.

Beginning July, we'll cover:

- Repairs provided by an authorized CRT equipment supplier.
- At least one preventative maintenance visit per year provided by an authorized CRT equipment supplier. As part of this visit, we'll cover related costs, including parts and services, labor, and the diagnostic and evaluation time required.

A qualified technician employed by the authorized CRT technology supplier must perform the preventive maintenance according to the manufacturer's guidelines and document and maintain a record of the services provided. Our members don't have to schedule a separate visit for preventive maintenance – CRT suppliers can perform preventive maintenance during visits for unrelated services.

Other CRT Coverage Policies

Medical documentation or proof for the continued need for repair or preventive maintenance isn't required for coverage. We'll also reimburse telehealth visits for CRT for dates of services on or after July 1. Please note, we may still require documentation of a medica necessity determination for CRT.

For more information about these changes, please review the legislation here.

Respiratory Care Supplies

You may receive requests for data downloads for DME equipment (such as CPAP and ventilators) from BlueCare or BlueCare's complex respiratory care vendor.

Breast Pumps

An electric breast pump can be provided with a physician order and by completing the information at https://aeroflowbreastpumps.com/qualify-through-insurance.

Incontinence Supplies

Codes for incontinence supplies and products listed below:

Note: Incontinence products only covered for members age 4 years and over if needed for a medical condition [See TennCare Rule 1200-13-13-.10(3)(b)17.(iii)], except infant Diapers are described in Rule .04, pharmacy program.

Note: Quantities >200 require prior authorization for the codes listed below. Beginning 5/1/2024, quantities >800 for wipes (A4335) will require review for medical necessity.

A4335	Incontinence supply; misc.	T4531	Pediatric, small/medium, pull-on
A4335SC	Diaper wipes/disposable washcloth	T4532	Pediatric, large, pull-on
A4554	Disposable underpads, any size	T4533	Youth, brief/diaper
T4521	Adult, small, brief/diaper	T4534	Youth, pull-on
T4522	Adult, medium, brief/diaper	T4535	Liner/shield/guard/pad/undergarment
T4523	Adult, large, brief/diaper	T4536	Pull-on, reusable, any size
T4524	Adult, extra-large, brief/diaper	T4537	Protective underpad, reusable, any size
T4525	Adult, pull-on, small	T4539	Diaper/brief, reusable
T4526	Adult, pull-on, medium	T4540	Protective underpad, reusable, chair size
T4527	Adult, pull-on, large	T4541	Disposable underpad, large
T4528	Adult, pull-on, extra large	T4542	Disposable underpad, small
T4529	Pediatric, small/medium, brief/diaper	T4543	Brief/Diaper, Bariatric
T4530	Pediatric, large, brief/diaper	T4544	Adult sized pull up diapers

H. Inpatient Admission Prior Authorization Requirements

(See Section XVIII. CoverKids of this manual regarding specifics for Medical Management and benefits.)

The Utilization Management team assists with discharge planning for members with specific or complex discharge needs who may need extra assistance with coordinating care post hospitalization. This includes assistance with coordinating services between settings of care. For assistance with discharge planning or transition of care needs, please call or fax the utilization management area (see contact numbers listed previously in this Utilization Management section).

The following inpatient services require prior authorization:

- All inpatient admissions;
- NICU admissions for Levels II, III, or IV (revenue codes 0172, 0173, and 0174) require authorization. However, providers may choose to submit authorization requests as soon as the baby is assigned a member ID. NICU authorization requests aren't subject to utilization management timely submission standards. Providers won't be issued a denial for non-compliance.
  Note: Revenue Codes 0170 and 0171 (newborn nursery care) do **not** require an authorization.
- Inpatient rehabilitation facility services (not covered for adults age 21 years and older unless determined to be a cost-effective alternative); and
- Skilled Nursing Facility (SNF) care (not covered unless determined to be a cost effective alternative).

Note: Maternity-related admissions do not require a prior authorization.

I. Behavioral Health Prior Authorization Requirements

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

The following behavioral health services require prior authorization:

- Inpatient
- Subacute Hospital
- Substance Use Disorder
- Residential Treatment
- Psychiatric Residential (Rehabilitation)
- Detoxification
- Psychiatric Partial Hospital
- Psychiatric Intensive Outpatient
- Applied Behavior Analyst Services
- Crisis Respite
- Crisis Stabilization (notification only)
- Home Health
- Electroconvulsive Therapy
- Transcranial Magnetic Stimulation
- Psychological Testing
- Comprehensive Child/Family treatment
- Continuous Treatment Team
- Program of Assertive and Community Treatment
- Supported Housing

The Division of TennCare requires all members being discharged from any behavioral healthcare service 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 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.

J. Home Health and Private Duty Nursing Prior Authorization Requirements

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

In Network Providers: Hourly Home Health Nursing, Hourly Home Health Aide and Private Duty Nursing require Prior Authorization. Intermittent services such as Home Health Nursing Visits, Home Health Aide Visits, Therapies and Social Worker Services, do not require Prior Authorization.

Out of Network Providers: All Home Health services require an authorization.

The home health agency is responsible for ensuring that the prior authorization process is completed within designated time frames.

Based on a State of Tennessee directive, **BlueCare Tennessee** is required to implement changes to BlueCare/TennCare*Select* 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 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 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:

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Limits for most TennCare Adults:

Home Health Aide Care	Home Health Nurse Care
➢ Up to 35 hours per week • No more than 8 hours/day • No more than 2 visits/day • HH aide and nurse combined cannot exceed 35 hours per week	➢ Up to 27 hours per week • No more than 8 hours/day • No more than 1 visit/day • HH nurse and aide care combined cannot exceed 35 hours per week
➢ 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:

Home Health Aide Care	Home Health Nurse Care
➢ Up to 40 hours per week combined aide and nurse per week • No more than 8 hours/day • No more than 2 visits/day • HH aide and nurse combined cannot exceed 40 hours per week	➢ Up to 30 hours per week • No more than 8 hours/day • No more than 1 visit/day • HH nurse and aide care combined cannot exceed 40 hours per week
➢ 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 or other licensed health care provider practicing within the scope of their license who is treating the member and provided by a licensed Home Health Agency pursuant to a plan of care at a member's place of residence:

1. Part-time or intermittent nursing visits;
2. Home health aide visits;
3. Hourly home health 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 childcare 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 24 hour period provided by a registered nurse or licensed practical nurse under the direction of the recipient's practitioner.

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
- TennCare*Select* member

Note: Requests for all Home Health Nursing and aide visits and services, as well as all Private Duty Nursing services for BlueCare and TennCare*Select* members should be submitted via e-Health Services on the company website, http://bluecare.bcbst.com or faxed to 1-800-292-5311.

Electronic Visit Verification (EVV)

Effective Jan. 1, 2023, all agencies that provide home health services to patients enrolled in a Medicaid plan must have an electronic visit verification (EVV) system in place for staff use to be in compliance with the 21st Century Cures Act. At a minimum, EVV systems should track the:

- Type of service performed
- Individual receiving services
- Date of service
- Location of service
- Individual providing the service
- Time the service begins and ends

Home health agencies can use the EVV vendor of their choice to capture the required data. The EVV vendor used by the home health agency must be connected to the MCO's aggregator in order to capture the visit information.

For more information or for any questions, please contact your Provider Network Manager. You can also access additional resources about EVV by visiting bluecare.bcbst.com/providers/tools-resources and choose **Resources for Home Health Providers.**

Please note that beginning July 1, 2023, we'll deny claims for home health services if an agency isn't using an electronic visit verification (EVV) system. As a reminder, all home health agencies treating members enrolled in a Medicaid plan must use an EVV system to track that member visits occurred as scheduled.

Please visit the bcbst.com website at https://bluecare.bcbst.com/providers/tools-resources/general/home-health to view all provider home health resources.

K. 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, TennCare*Select*, 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 TennCare*Select* reviews requests based on medical necessity. The guidelines utilized are applied in the following hierarchy:

- TennCare Rules located at http://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm;
- BCBST Medical Policy located https://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm;
- MCG adopted guidelines (formerly Milliman Care Guidelines®) by BlueCare Tennessee, and
- Centers for Medicare & Medicaid Services (CMS) and Local Coverage Determinations (LCD) located at http://cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

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, TennCare*Select*, 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.

L. Documentation Required

Prior Authorization Requests can be submitted using the Availity web portal, fax, or phone.

Submit the following required information for all Prior Authorization Requests (subject to covered benefits). BlueCare Tennessee will accept verbal, electronic and written orders from the ordering physician or other licensed health care provider practicing within the scope of their license who is treating the member. 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

BlueCare doesn't require the actual order. It is the servicing provider's responsibility to obtain the signed order from the ordering physician or other licensed health care provider practicing within the scope of their license and ensure the signed order is on file. BlueCare Tennessee can request the order at any time.

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

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 (subject to covered benefits)

Home health authorizations are to be submitted via e-Health Services® on the company websites, www.bcbst.com or http://bluecare.bcbst.com. The home health agency must have an order from the ordering physician or other licensed health care provider practicing within the scope of their license along with the following information:

- Name of practitioner prescribing the service(s) with a signed and dated MD or licensed health care provider 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.*

M. Timely Submission of Prior Authorization Requests

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.
- Urgent/emergent inpatient admissions are not subject to timely submission standards. Inpatient admissions continue to require authorization for claims payment, and facilities must submit clinical information to ensure inpatient care is medically necessary. Timely submission of clinical information will help us assist you with discharge planning needs (excluding acute inpatient Behavioral Health facilities which are required to submit authorization requests within 24 hours or one business day).
- Durable **Medical Equipment (DME) and Orthotics and Prosthetics (O&P)**
  Authorization is required within three business days (excludes weekends/holidays) from services being provided to the member.
- **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 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** 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, TennCare*Select* or CoverKids.

N. 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 Clinical Review Managers 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 7 calendar days following the receipt of the request for service, with a possible extension of up to 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 72 hours after the receipt of the request for service.

BlueCare Tennessee may extend the 72-hour time period by up to 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.

O. 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.

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.

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*)

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*, CoverKids, 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*, CoverKids, 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 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.

Centers for Medicare & Medicaid Services (CMS) Guidelines

BlueCare Tennessee Medical Management Program utilizes Medicare Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) as a resource for review and determinations. LCDs and NCDs are utilized by BlueCare Tennessee for determining appropriate codes and medical necessity when criteria is not available through TennCare Guidelines, 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.

CMS policies may be either national or local. National policies are established by the Centers for Medicare & Medicaid Services (CMS). Local policies are developed by Medicare Administrative Contractors (MAC) The intent of the policy development process is to provide the opportunity for input from providers and the medical community to assure the final policy is consistent with sound medical practice.

P. 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 visiting http://www.Availity.com or by calling Utilization Management at 1-888-423-0131 for BlueCare, 1-800-711-4104 for TennCare*Select*, 1-800-924-7141 for CoverKids, 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 of UM Decision

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.

2. Member Appeal to TennCare

For services that **have not been** rendered, members can appeal to the Division of TennCare within 60 days of the date on the denial notice. Providers can appeal on the behalf of the member by obtaining written authorization from the member. Providers must complete the appeal form which includes obtaining the member's signature. The TennCare Medical Appeal form can be viewed online at: https://www.tn.gov/content/dam/tn/tenncare/documents/medappeal.pdf

There are 3 ways to file your appeal:

1. **Call** : Call TennCare at 1-800-878-3192, Monday through Friday during the hours of 8 a.m. to 4:30 p.m., Central time.
2. **Fax**: Fax the TennCare Medical Appeal form for free to 1-888-345-5575
3. **Mail**: Mail the TennCare Medical Form to:

   TennCare Member Medical Appeals
   P.O. Box 000593
   Nashville, TN 37202-0593

3. 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
- 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 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*, 1-800-924-7141 for CoverKids, or 1-888-747-8955 for CHOICES/ECF CHOICES, Monday through Friday, 8 a.m. to 6 p.m. (ET).

4. Standard Clinical Provider Appeal

The Standard Clinical Provider Appeal process can be used if the service **has been rendered**. Requests for Standard Clinical Provider Appeals for denied services must be received in writing by the Utilization Management Appeals Department within 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 Documents & Forms | BlueCare Tennessee. A determination will be sent to the provider within 30 days of the receipt of the request for appeal. Fax Appeal requests to:

BlueCare Tennessee Appeals Department
Attention: (BlueCare/TennCare*Select*, CoverKids, CHOICES/ECF CHOICES) UM Appeals Department (specify)
FAX: 1-888-357-1916

Note: Use of dedicated fax number will help ensure all faxed standard clinical provider 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.

If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. D. of the Provider Dispute Resolution Process. For more information on the Provider Dispute Procedure, see Section XII. Highlights of Provider Agreement in this Manual.

5. Non-Compliance Denial Appeal

Some authorizations are denied as non-compliant. An authorization could be denied for reasons such as a request that is made past the required time frame or insufficient documentation. If the provider is dissatisfied with a non-compliance denial, they may appeal the denial. Appeals of non-compliance denials must be submitted within 60 days of the initial denial notification to the provider. The request from the provider 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 initial denial letter. A decision will be sent to the provider within 30 days of the receipt of the request for appeal. It may be filed in the following manner:

Mail to:	BlueCare Tennessee Appeals
	1 Cameron Hill Circle
	Chattanooga, TN 37402
Fax:	(423) 535-1959

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 Process.

Q. Continuation of Benefits for Private Duty Nursing and Home Health Agency Services for Members Over 21 Years

(Does not apply to CoverKids)

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 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 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 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.

R. Retrospective Claims 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 and/or a claim reconsideration that contains medical records.

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

➢ **Abortion, Sterilization and Hysterectomy (ASH)**

Abortions, sterilizations and hysterectomies are reviewed to comply with federal and state 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 and state 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, Sterilization Consent form, Certification of medical necessity for Abortion 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/tenncare-provider-news-notices-forms/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.**

➢ **Emergency Room**

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.

Note: Reconsiderations for Emergency Room with medical records can be faxed to 423-535-1920.

➢ **Durable Medical Equipment (DME) Repairs**

DME repairs are subject to retrospective review. All non-complex rehab technology (CRT) repairs are reviewed for medical necessity.

CRT repairs are not subject to medical necessity review however, effective **July 1, 2024**, BlueCare, TennCare*Select* and CoverKids cover and reimburse medically necessary repairs on complex rehab technology (CRT) annual for at least once preventive maintenance visit. The repairs must be provided by an authorized CRT equipment supplier.

CRT providers are required to complete the Tennessee Department of Commerce and Insurance's CRT Attestation Form and submit it with their claim. All paid claims are subject to provider audit and recoupment if no attestation form is on file.

S. Referrals

Completion of the referral form for BlueCare, TennCare*Select*, CoverKids, 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 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, https://bluecare.bcbst.com/providers/tools-resources/ or a paper copy is available only to BlueCare, TennCare*Select*, CHOICES, or ECF CHOICES PCPs and OB/GYNs by calling the BlueCare provider Service

line, 1-800-468-9736 or 1-800-924-7141 for CoverKids. 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 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.

T. Other Services

(See Section XVIII. CoverKids of this Manual regarding specifics for Medical Management and benefits.)

Vision Services

For vision-specific benefits, see Section V. Billing and Reimbursement in this Manual.

Dental Services

Effective 1/1/2023, Dental services are covered for all BlueCare/TennCare*Select* members.

All dental services are provided to members through one statewide Dental Benefit Manager (DBM). Services are provided as medically necessary to treat the oral health needs of these members. Until Oct. 31, 2025, please call DentaQuest Customer Service at 1-800-294-9650 if you need more information. Effective Nov. 1, 2025, Renaissance will be administering our members' dental benefits. If you need additional information after Nov. 1, please call Renaissance at 1-866-864-2526.

Facility, medical and anesthesia services related to a dental service that are not provided by a dentist or in a dentist's office are covered by BlueCare when the dental service is covered by the dental benefits manager (DBM) or the Tennessee Department of Disability and Aging (DDA).

Adult dental benefits are not applicable to members who have CoverKids. CoverKids children have dental benefits through age 18.

U. Department of Children's Services (DCS) and Safety Admissions

TennCare*Select* 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 TennCare*Select* member, when DCS places a child in state custody, the child becomes a TennCare*Select* member. TennCare*Select* 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, TennCare*Select* will pay for the child to be admitted to the hospital until a safe residence is available for the child.

V. Emergency Services

Medical 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 $8.20 - $50.00 copay is charged to uninsured and uninsurable BlueCare Tennessee members presenting to the emergency room. This Copay amount is waived if the member is admitted.

Prescription Drug Emergency Services

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†. See Billing Procedures, Section V.O. Pharmacy Benefits Manager (PBM) Program.

†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/managed-care-contractors/pharmacy-benefits-manager.html.

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):

Memphis Region	1-866-791-9226	Southeast TN	1-866-791-9225
Rural West TN	1-866-791-9227	East Region	1-866-791-9224
South Middle	1-866-791-9222	Frontier Health (NE TN)	1-877-928-9062
North Middle TN Mental Health Co-Op (Davidson)	1-866-791-9221 1-615-726-0125	Helen Ross McNabb (Monroe, Blount, Sevier, Loudon, Knox)	1-865-539-2409

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 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.

Please see the TN Division of TennCare's "Frequently Asked Questions" regarding the following: Mobile Crisis, Emergency Involuntary Admission Process, Mandatory Pre-Screened Agents, and Crisis Stabilization Unit.

https://www.tn.gov/content/dam/tn/mentalhealth/documents/FAQs_Psychiatric_Crisis_Delivery_System_April_25_2017.pdf

W. 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.

X. Health Department Services (Does not apply to CoverKids)

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 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.

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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. BlueCare Tennessee (BCT) provider Maternity Care Management Notification may be submitted online throughout Availity Payer Spaces application. Please see the BCT website for additional information on submitting this form and steps to receive payment: https://bluecare.bcbst.com/providers/quality-initiatives/maternity.

Network facilities are not required to notify BCT 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.

All pregnant BlueCare Members are eligible for digital care management to provide continuous one-on-one support from their care team throughout their pregnancy and postpartum. A care manager will encourage engagement with the provider, provide care coordination services, and identify and resolve barriers to care through referrals to community-based resources. Providers can refer Members for these services. A full description of BlueCare maternity care management services can be found in Section X. Population Health Management of this Manual.

Note: If sterilization services are requested, the treating OB is required to follow the state sterilization consent process.

A. Prenatal Standards

Prenatal care must be delivered in accordance with current American College of Obstetricians and Gynecologists (ACOG) guidelines for perinatal care. These guidelines are available for purchase online at Guidelines for Perinatal Care | AAP Books | American Academy of Pediatrics

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 Obstetricians and Gynecologists (ACOG) criteria in referring high-risk pregnancies to either an OB/GYN or perinatologist.

Providers can refer Members to receive enhanced care management support including, but not limited to, digital care management. A full description of BlueCare maternity care management services can be found in Section X. Population Health Management of this Manual.

C. Presumptive Eligibility

(Does not apply to CoverKids)

Practitioners may direct their Tennessee patients who are pregnant and without health insurance to apply for full Medicaid coverage through TennCareConnect at https://tenncareconnect.tn.gov or through the Health Insurance Marketplace at https://www.healthcare.gov/ or 1-800-318-2596.

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 may direct their Tennessee patients 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 for full coverage.

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 presumptive eligibility time frame or TennCare eligibility is denied,* **BCT** *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 presumptive period.*

The following guidelines apply for BlueCare or TennCare*Select* Presumptive Eligible Enrollees:

1. Tennessee Health Departments and qualified hospitals for Presumptive Eligibility (PE) process are authorized to grant presumptive eligibility to pregnant women residing in the State of Tennessee. The health department and qualified hospitals require 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 TennCare*Select* ID card in approximately two (2) weeks. The Member should present her carbon copy of the presumptive eligibility form during the presumptive eligibility period or her ID card each time she seeks care.
3. The health department or member makes the first prenatal appointment with a BlueCare/TennCare*Select* 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/TennCare*Select* (MCO # 00-02 or 00-19) is the Enrollee's designated MCO. (**Note:** *New Members are automatically assigned a* 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 BCT does not show eligibility information in its system on a Member who presents a presumptive eligibility form to a Practitioner, BCT will contact the issuing health department to resubmit eligibility information. A BCT customer service associate will share eligibility results, via telephone, with the Practitioner's office.

BCT 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 BCT as a material breach of contract.

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X. Population Health Management Program

The entire BlueCare, TennCare*Select*, and CoverKids enrollee population, including non-CHOICES members, CHOICES members, Intellectual/Development Disability Managed Long-Term Services and Supports (I/DD MLTSS) members, dual-eligible CHOICES members, and dual-eligible I/DD MLTSS members are enrolled in the Population Health (PH) Management Program. Certain member populations are excluded from outreach due to their eligibility classifications. Members are identified and placed in specific PH cohorts across the entire care continuum – including low- or no-risk level, rising risks and high risks. Members receive outreach and support from their integrated care team according to their placement.

The PH Management Program is an opt-out program; services are provided to all eligible members unless they specifically ask to be excluded.

A. Components

PH Integrated Care Team staff connect members to services that assist them in self-managing their health, accessing needed care, and connecting with providers and community resources. All PH Management Program activities include clinical reminders around preventive care, and after-hours assistance with urgent or emergent member needs. Cohort content and interventions are based on documented objectives, member assessments and risk stratification. PH activities, interventions, and education objectives vary for each cohort, with increasing engagement and intensity as the member's level of risk increases. This cohort approach includes four **activities and interventions:**

1. Helping healthy individuals stay healthy

Wellness, prevention, and health promotion

Wellness, prevention, and health promotion activities are designed to engage members with no identified health risk to ensure healthy members stay healthy. Members are provided with one non-interactive education outreach quarterly to address these within one year:

- 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, vaping and the dangers of exposure, weight management, stress management, physical activity and substance abuse prevention)
- Healthy nutrition
- Other healthy and safe life-styles choices

2. Helping Members manage their own health risk

Low-risk members

Low risk cohorts provide self-management education and support to members with rising risk and chronic care needs and then, empowering them with the tools and educational materials necessary to make the most informed decisions about their health. The goal of these cohorts is to improve the quality of life, health status, and utilization of services by providing intense self-management education and support.

For documented non-interactive communications include self-management education that emphasizes:

- Increasing the member's knowledge of chronic health conditions
- The importance of medication adherence
- Appropriate lifestyle/behavioral changes
- Management of the emotional aspect of health conditions
- Self-efficacy and support
- Individualized support for self-management that the member desires to become engaged
- A 24/7 nurse advice line

- Health coaching
- Availability of community resources

Low-risk maternity

Low risk cohorts include maternity services with the goal to engage pregnant individuals into timely prenatal and postpartum care, aim for delivery of a healthy, full-term infant without complications and maintain and promote the health of the mother. All members identified as being pregnant receive an invitation to enroll in our digital care management platform. Members who engage in care management (telephonic or digital) receive health risk screenings (including tobacco use, mental health, and substance misuse). We provide education on pregnancy, newborn care, and inter-conception health and offer appointment scheduling assistance, assistance with provider engagement with a provider for prenatal and postpartum care, and resolving barriers to care. All identified pregnant members receive all low-risk PH cohort minimum interventions plus:

- Access number to appropriate support from their care team including a nurse/social worker when appropriate
- Assistance to help the member become established with a provider, receive prenatal and postpartum visits, and receive a postpartum depression screening
- Follow-up to ensure member is established with a provider and reconnection back to primary care after delivery
- Referrals to appropriate community-based resources and follow-up for these referrals

Provider maternity assessments (Maternity Care Management Notification form) may be submitted online in the Availity Payer Spaces application. The obstetrician or primary care physician (PCP) providing prenatal care should submit this form within 30 days of the member's first appointment. For further details about this form and submission, please see section IX. OB Services.

Care coordination

Care coordination services are available for members who may or may not have a chronic disease but have acute health care needs, health service or social needs or risks which need immediate attention. These services help ensure members get the services they need to prevent or reduce an adverse health outcome. Services may include assistance in making and keeping needed medical or behavioral health appointments; hospital discharge instructions, health coaching, referrals related to the member's immediate medical, behavioral, or social needs; PCP reconnection; and offering other resources and materials related to wellness, lifestyle and prevention. Enhanced care coordination is offered to members with identified unmet social needs. Non-medical risk factor data is incorporated into care coordination and targeted intervention strategies for members with unmet social needs.

3. Helping individuals with complex health problems better manage their condition

Members with high-risk needs

High risk cohorts are designed to manage members with complex or high-risk health needs. The goal of these cohorts is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. Our identified cohorts of members include similar risk and health utilization patterns where interventions have the highest opportunity to drive change and target impactable spend, leading to better cost control and outcomes. Our outreach strategy for each cohort is customized to address the member's needs. Member Care Management services include comprehensive assessment, care planning and goal management. These services may be delivered telephonically, digitally, or in person as appropriate.

Members identified as high risk receive the interventions provided to all members. In addition, our high risk-members may require more intensive services through telephone, digital and in-person support which may address issues, such as:

- Primary Care and/or Specialist Engagement
- Discharge Planning
- Medication Adherence/Reconciliation
- Durable Medical Equipment/Services
- Social Needs

- Transportation
- Compliance with condition specific care guidelines - such as testing and physician appointments
- Effects of illness on a member and their family
- Modifiable risk factors, such as diet, exercise or smoking
- Ability to understand educational materials
- Review of plan of care and goals achieved
- Absence of family or other support system
- Ensuring coordination with other supports such as behavioral health or community agencies

We believe that complex, high-risk members may benefit from working with a Case Manager to develop specific goals that help to maintain and continually improve health outcomes. When a member is identified as needing this additional support, the case manager engages the member and establishes a relationship with the goal of working together to identify needs and barriers to achieving better health. This leads to establishing specific, measurable, attainable, relevant and timely (SMART) goals that drive meaningful outcomes, based on a comprehensive assessment and a well-developed plan of care.

The Care Plan is reviewed with the member during development and agreed to by the member. It may be shared with other members of the care team, including the physician. The plan is followed according to the time frames included in the plan. The Case Manager works with the member in person, digitally, or telephonically, as appropriate and reviews and prioritizes goals. Cases usually are open for management between 60-120 days or longer if needed to achieve goals. As goals are reached, the plan reflects the date the goals were met.

Utilizing state-of-the-art technology and risk management tools, we can identify members with 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.

We use the Case Management Society of America (CMSA) Integrated Case Management (ICM) Model which supports assessment and care planning designed to build rapport, improve engagement, and reinforces the practitioner/patient relationship, while empowering members to become more effective at self-management of their condition.

Complex-Case Management cohort processes are monitored for compliance with the National Committee for Quality Assurance (NCQA) standards in order to maintain accreditation.

For members engaged in a high-risk cohort, we provide a minimum of monthly interactions with the member that include 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 the member's condition
- Develop and implement an individualized care plan
- Teach problem solving techniques
- Evaluate and support the emotional impact of the member's condition
- Encourage self-efficacy
- Provide referrals and resources 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

Complex case management

Complex case management is a collaborative member-centered process that includes comprehensive assessment, planning, facilitation and advocacy for options and services to meet an individual's physical or behavioral health and social needs through communication and available resources to promote quality, cost-effective outcomes. Complex Case Management services are for members who've experienced a significant health event or diagnosis requiring intensive coordination of care using our Integrated Care Team approach and the extensive use of resources. Members are considered eligible for Complex Case Management upon identification unless they subsequently opt out.

The overall goal is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. Complex Case Management aims to facilitate timely delivery of

appropriate individual health care services across the continuum of care in various settings for members with complex and catastrophic conditions while providing self-management support.

After the population is stratified, identified members are segmented into complex case management. Members are considered identified on the date the case is created. All eligible members will have three outreach attempts within 30 calendar days of their identification. Members known to have urgent or critical needs may receive additional outreach attempts and varied types of contact may be indicated. This group includes:

- Members that have high risk, unique or complex needs, including multiple comorbidities and/or high utilization
- Members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions
- Members who've experienced a significant health event or diagnosis that requires extensive use of resources
- Members with Sickle Cell Disease who have inpatient and ED utilization and/or receiving cell gene therapy treatment

Members may also be considered for complex case management by internal or external referrals and health risk assessments.

Members receive a minimum of monthly contact from the case manager and may receive a face-to-face visit by the case manager if needed. Members engaged in complex case management receive all high-risk minimum interventions.

High Risk Maternity

The High Risk Maternity cohort is designed to support expectant mothers identified as having elevated medical, behavioral or social risks during pregnancy. The cohort's primary goal is to engage pregnant members in timely prenatal and postpartum care, aiming for the delivery of a healthy, full-term infant without complications and a safe, supported postpartum recovery. Once identified, high risk pregnant members receive comprehensive pregnancy education information and they can choose to be enrolled in care management. Throughout their pregnancy, enrolled members receive at least monthly personalized outreach from their Integrated Care Team, which may include a face-to-face visit if needed, digital maternity support, and telephonic case management. More frequent contact is initiated if prenatal appointments are missed, or additional support is needed. The care team – comprised of health navigators, pharmacy specialists, nurses, social workers, health educators, dietitians, and behavioral health specialists – works collaboratively with providers and OB specialists to ensure coordinated, whole-person care. Their efforts focus on:

- Ensure the member is established with a provider for prenatal and postpartum care and postpartum depression screening and assist with addressing any barriers to becoming engaged in their care
- Complete a comprehensive health risk assessment to include screening for mental health and substance misuse
- Develop and implement an individualized care plan to include information on pregnancy, newborn, and inter-conception health
- Provide information on healthy lifestyle habits such as the availability of tobacco cessation benefits, (including the TN Tobacco Quit Line), exercise, nutrition, birth spacing, and one-on-one support from a certified Health Educator, Social Worker or Dietitian
- Provide support for pregnant and postpartum members with substance use disorder, including opioids
- Refer to appropriate community-based resources to assist with unmet social needs and follow-up for these referrals
- Engage member in fourth trimester care, including postpartum visits, lactation support, contraceptive counseling, depression screening and appropriate transition to the PCP or specialist, as needed.

4. Integration with CHOICES and I/DD MLTSS Programs

To ensure Population Health (PH) Management Program activities are integrated with CHOICES care coordination or I/DD MLTSS support coordination processes and functions, the assigned PH Care Manager will communicate with the CHOICES care coordinator or I/DD MLTSS support coordinator via phone call, email or the system of record, to inform them of member identification for PH Care Management program outreach. Once member outreach has occurred, the PH Care Manager will provide the CHOICES care

coordinator or I/DD MLTSS support coordinator with applicable information collected during the outreach that includes:

- Completed assessment information
- Educational materials provided
- Needed appointments/screenings (gaps in care)
- Plan of care
- The provider who received notification of the member's participation in the PH management program

The care coordinator or support coordinator will review the educational materials verbally with the member and with their caregiver or representative (as applicable). It will remain the assigned care coordinator's or support coordinator's primary responsibility for the coordination of the member's physical health, behavioral health, and long-term services and supports. PH staff must supplement but not replace the role and responsibilities of the member's care coordinator/care coordination or Support Coordinator/support coordination team.

PH Management interventions utilize evidence-based Clinical Practice Guidelines (CPGs). National guidelines are reviewed annually, or more frequently if national guidelines change within that period, by the Enterprise Quality Oversight Committee (EQOC); a hardcopy of each CPG is retained in the Medical Policy Research and Development Department. Educational materials are reviewed and updated concurrently with the update of the CPGs. Copies of the CPG are available to enrollees upon request. We may develop modified CPGs based on the Division of TennCare guidelines and/or nationally recognized standards.

These guidelines are monitored and reported annually to the EQOC.

B. Referral and Enrollment

Please call **1-888-416-3025** to refer BlueCare, TennCare*Select* or CoverKids Members in need of assistance from the PH Care Team.

Note: Our provider maternity assessments (**Maternity Care Management Notification**) may be submitted online via the Availity Payer Spaces application, https://www.availity.com.

C. Evaluation of the Population Health Management Program

The PH Management Program monitors population health data such as engagement, care management activities (e.g. care plan and discharge information), Social Determinants of Health, maternal health metrics. The program is evaluated on an annual basis using performance measures that are compared to measurable benchmarks and goals including Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Key performance measures in the annual evaluation include utilization, maternity, chronic/complex custom and HEDIS measures. Based on outcome measurements, program activities are added or modified for continued quality improvement of effective and cost-efficient services.

The system of record contains 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). We maintain a centralized information system, and its capabilities include supporting cohort identification, completing member assessments, collecting and reporting member behavioral changes, documenting interactive and non-interactive member touches as needed for follow-up confirmations and determining intervention outcomes.

D. Contact Us

If you have questions about the programs, or would like a copy of the educational material, call our PH Management department at **1-888-416-3025.**

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*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

XI. Quality Improvement Program

A. Introduction

BlueCare Tennessee (BCT) is committed to improving the quality and safety of care and service to its members. BCT demonstrates this commitment through the implementation of a comprehensive Population Health Quality Improvement Program (PHQIP), which provides the structure that supports quality improvement (QI) activities.

The PHQIP 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, long-term services, and I/DD (Intellectual/Development Disability) MLTSS (Managed Long-Term Services and Supports) to our members, while achieving member and provider satisfaction.

The PHQIP provides leadership for implementation of comprehensive QI initiatives for BCT 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, BCT is able to provide *local solutions with meaningful results.*

Purpose

The purpose of the PHQIP 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. BCT Practitioners and Providers will allow their performance data to be used for QI 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 BCT QI Program. Within its scope, BCT focuses on the following priorities that are listed in the ACA:

- Have the greatest potential for improving the health outcomes, efficiency and patient-centeredness of health care for all populations, including children and vulnerable populations
- Identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care
- Improve Federal payment policy to emphasize quality and efficiency
- 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
- Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections
- 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, BCT 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.

BCT 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, 1915 (c) waivers, and Employment and Community First (ECF) CHOICES, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). 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.

BCT works to serve our TennCare population. Various lines of business within BCT manage the care of diverse populations in varied geographies and health care delivery systems. These populations include:

- Children under age 21
- Pregnant women
- Parents or Caretakers of a minor child. (The Child must live with parent or caretaker and be a close relative.)
- Individuals who need treatment for breast or cervical cancer
- People who receive Supplemental Security Income (SSI).
- Individuals with intellectual and developmental disabilities (I/DD)
- Katie Beckett Program Participants
- People who have received both an SSI check and a Social Security check for the same month at least once since April 1977 AND who still receive a Social Security check
- People who live in a medical institution like a nursing home and have income below $2,901 per month OR receive other long-term care services that TennCare pays for

Key clinical and service indicators such as HEDIS rates are used to measure performance and effectiveness of QI initiatives. BCT HEDIS priorities include the following:

Triple-Weighted Measures

- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Blood Pressure Control (<140/90) for Patients with Diabetes (BPD)
- Childhood Immunization Status - Combination 10 (CIS-E)
- Immunizations for Adolescents – Combination 2 (IMA-E)
- Controlling High Blood Pressure (CBP)

Prevention/Screening Measures

- Well Child Visits (W30-15 months)
- Well Child Visits (W30-15-30 months)
- Child & Adolescent Well-Care Visits (WCV)
- Breast Cancer Screening (BCS-E)
- Colorectal Cancer Screening (COL-E)
- Prenatal & Postpartum Care (PPC)
- Adult Immunization Status (AIS-E)

Multiple Chronic Illnesses

- Statin Therapy for Patients with Cardiovascular Disease (SPC)

Managing Members with Emerging Risks

- Eye Exam for Patients with Diabetes (EED)

Behavioral Health

- Follow Up After Hospitalization for Mental Illness – 7-day and 30-day (FUH)
- Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 Day (FUA)

Utilization Measures

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

- Emergency Department Utilization (EDU)
- PCP Utilization
- Plan All-Cause Readmissions 30-Day (PCR)

LTSS HEDIS

- Comprehensive Assessment & Update (CAU)
- Comprehensive Care Plan & Update (CPU)
- Reassessment/Care Plan Update After Inpatient Discharge (RAC)
- Shared Care Plan with Primary Care Practitioner (SCP)

Culturally and Linguistically Appropriate Care

An annual analysis of member race, ethnic origin, disability status, sex, and language capacity is conducted in order to assess the organization's availability of network Practitioners for meeting the racial, ethnic, disability, sex and linguistic needs of its diverse membership.

In-depth data analyses and collection of population-specific metrics are utilized, which serves as the foundation for a culturally and linguistically diverse membership. The analysis of significant health care disparity data in various clinical areas functions as the foundation of BlueCare population health management program and guides all ethnic, racial, disability 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 Care Management and Outreach Departments utilize the data collected on the five (5) demographic categories (race, ethnicity, sex, 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 QI activities; thus, improving the health disparities facing BCT's members.

In addition to collecting and addressing members' needs, BCT offers providers resources to enhance cultural competency. Providers have access to training resources via the BlueCare website at https://bluecare.bcbst.com/providers/tools-resources/documents-forms.

Clinical Practice Guidelines (CPGs)

BCT 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.

BCT 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 located on the company website at Manuals, Policies & Guidelines | BlueCare Tennessee. Paper copies of these guidelines are available upon request by calling 1-888-423-8221.

Goals, Objectives, and Strategy

BCT supports the Division of TennCare Quality Strategy. The Division of TennCare's commitment to quality and continuous improvement in the lives of Tennesseans is reflected in its Vision and Mission Statements: "A healthier Tennessee" and "Improving lives through high-quality cost-effective care." All QI activities of the Division of TennCare are consistent with the National Quality Strategy for better care, healthy people/healthy communities, and affordable care. The complete Division of TennCare Quality Strategy can be found at https://www.tn.gov/content/dam/tn/tenncare/documents2/2025DraftQualityImprovementStrategy.pdf

The BCT PHQIP documents the planned activities to improve quality of clinical care, safety of clinical care, quality of services, and member experience. The BCT PHQIP also promotes integration of physical health, behavioral health, and Long-Term Services and Supports (LTSS) for all BCT members, while achieving both member and provider satisfaction. BCT succeeds in QI efforts by fostering an internal culture of quality,

*CAHPS® is a registered trademark of the Agency for Healthcare Research & Quality (AHRQ).

addressing health care disparities, and continual research of health care best practices.

Strategic Goals and Objectives of the BCT PHQIP:

Quality Goals

- Best Tennessee Medicaid Program (TennCare) Managed Care Organization (MCO)
  - Remain the leader in innovation
  - Highest NCQA rated health plan
  - Deliver the highest value
- Execute on the Centers for Medicare and Medicaid (CMS) National Quality Strategy Priority Areas
  - Improve quality and health outcomes across the care journey
  - Align and coordinate across programs and care settings
  - Advance health equity and whole-person care
  - Engage individuals and communities to become partners in their care
  - Achieve zero preventable harm
  - Enable a responsive and resilient health care system to improve quality
  - Accelerate and support the transition to a digital and data driven health care system
  - Transform health care using science, analytics, and technology

Objectives

- Effective health care cost and utilization
- Improved health care delivery and coordination (medical, behavioral, socioeconomic, physical environment, LTSS, Intellectual and Developmental Disabilities (I/DD) Managed Long-Term Services and Support (MLTSS)
- Improved health outcomes/status
- Reduced health care disparities

Operational Strategies

- Aligned data-driven Clinical Quality Improvement (CQI) and innovation across BCT
- Member activation for improved access and health behaviors
- Provider engagement and support for CQI
- Strong community partnerships for quality
- Employee activation for a culture of quality

Information about the QI Program (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 QI Program, please call 888-423-8221 or visit the BCT website Provider page at http://bluecare.bcbst.com/providers.

B. Scope of Responsibility

The BCT CQI Department is responsible, in conjunction with the Vice President & Chief Medical Officer or designee, for developing, coordinating, and implementing clinical and process quality initiatives for BCT. Collaboration with and support from other departments within the division, such as Medicaid Operations, Population Health, Provider, and Member and Outreach areas, are vital to achieve QI 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 BCT leaders and Corporate Quality Management to meet external quality information needs. The CQI Department provides operational leadership for BCT HEDIS interventions, member/provider satisfaction and quality indicator reporting.

The CQI 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 PHQIP for BCT to meet the demographic and epidemiological needs of the population served. CQI conducts the following activities:

- Establishing BCT PHQI Program objectives and annual goals in collaboration with the Executive Team
- Defining the organization's quality structure and strategy
- Overseeing monitoring and reporting of BCT quality indicators
- Leading the development, implementation, and evaluation of provider and member-facing QI initiatives to improve quality, promote appropriate utilization, and enhance operational efficiencies
- Ensuring member safety through investigation of Quality of Care (QOC) concerns
- Leading member/provider satisfaction survey processes
- Engaging physicians and other healthcare providers to improve member health outcomes, satisfaction, and experience
- Facilitating continuity and coordination of care across providers
- Conducting provider site visits to monitor compliance with regulatory and contractual requirements and ensuring member needs are met
- Monitoring Buprenorphine Enhanced and Supportive Medication Assisted Recovery and Treatment (BESMART) Network providers treating members with opioid use disorder
- Monitoring care coordination for TennCare members with the highest BH needs through the Tennessee Health Link (THL) Program
- Monitoring provider surveys conducted by the Department of Disability and Aging (DDA)
- Leading HEDIS (Traditional/LTSS) reporting and implementation of action plans to achieve targeted improvement goals
- Supporting clinical initiatives related to CAHPS performance
- Ensuring compliance with State and Federal quality improvement and assurance requirements
- Maintaining compliance with NCQA Accreditation standards and External Quality Review Organization (EQRO) requirements
- Overseeing quality review processes, including evaluation and recommendations for improvement
- Supporting initiatives to reduce health disparities and promote culturally and linguistically appropriate care and services
- Overseeing strategies to advance equitable care and services

CQI supports Population Health Case Management and Utilization Management across both physical and behavioral health services. In behavioral health utilization management, CQI focuses on monitoring coordination between physical and behavioral health care. CQI also provides support for the BCT CHOICES, ECF CHOICES, and Katie Beckett services.

Care coordination is achieved through an ongoing assessment of the members' physical, behavioral, functional, and psychosocial needs to determine appropriate services.

The QIP services all members and includes participation from, but is not limited to, primary care and specialty providers, institutional and non-institutional care settings, and internal operations.

C. Structure

The BCT CQI structure is driven by unique areas within the CQI Department under the direction of the Director of CQI and supported by the BCT President & Chief Executive Officer and Vice President & Chief Medical Officer. Additional program input is sought through direct collaboration with the Medical Directors of DSNP & CHOICES.

These areas are as follows:

- Clinical Strategy and Evaluation
- Quality of Care Oversight

Functional responsibilities of the CQI Department include:

- Clinical and Non-Clinical Performance Improvement Projects

- HEDIS and CAHPS Strategy Oversight
- Accreditation and Regulatory Compliance
- Clinical Practice Guidelines (CPGs) and evidence based best practice research
- Annual Documents (PHQI Program Description, PHQI Program Evaluation, Work plan)
- Satisfaction Surveys (Member and Provider)
- ECF Provider Survey
- Quality Review Audits
- Focused Improvement and Corrective Action Plans
- Committee and Clinical Advisory Panel Coordination
- Policy/Procedure Coordination
- Process Improvement Initiatives
- Reportable Events Management
- Home Health Critical Incidents
- Unexpected Death Reporting

The CQI Department collaborates with all departments within BCT to identify, monitor and evaluate quality indicators. Quality indicators and/or QI 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 Quality program documents
- Annual review of criteria used to assist in medical necessity determinations
- Clinical quality indicators
- Critical Incidents
- Health Outcomes Survey
- Member and Provider Satisfaction

Committee Structure

The CQI Department is responsible to provide leadership for the communication of QI activities and outcomes. This information is communicated to both executives and staff through vertical and horizontal communication strategies as outlined in the BCT committee structure.

BCT Quality Leadership Council (QLC)

The function of the BCT QLC is to provide oversight and monitoring of BCT Population Health Quality and Operational strategies and oversee BCT's QI program and functions to ensure accreditation, contract and regulatory compliance.

This Committee has oversight over:

- BlueCare Plus Quality Committee
- BCT Member Experience Committee
- BCT Primary Care Clinical Advisory Panel
- BCT Maternal Health Clinical Advisory Panel
- BCT Sickle Cell Clinical Advisory Panel
- BlueCare Member Advisory Panels
- BlueCare Quality Workgroups

The BCT QLC has been delegated by BCT's Board of Directors (BOD) to provide oversight of the QI Program and thus recommend approval of all related QI annual documents.

Program Evaluation and Work Plan

The overall effectiveness of the PHQI Program is evaluated 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 Population Health QI activities
- Population Health and QI activities initiated throughout the year, updated to address member needs as necessary
- Population Health and QI resources, updated to address member needs as necessary
- Trending of clinical, service and other performance measures
- Analysis of results to demonstrated QI
- Identified opportunities for improvement
- Culturally and linguistically appropriate services
- Overall effectiveness of the BCT PHQIP
- Population Health Annual Report
- Goals and recommendations for the work plan for the upcoming year
- Effectiveness and efficiency of Utilization Management (UM) processes, which are evaluated and documented in an annual UM Program summary/evaluation

The work plan focuses on specific program goals, objectives, and planned activities for the upcoming year. It also identifies responsible individuals, establishes timelines for completion, and outlines committee reporting. The work plan is utilized as an action plan to document the status of activities and achievement of goals throughout the year.

These are updated and submitted to the BlueCare Quality Committee Structure for review, comments, and recommendations for revisions.

The annual evaluation, work plans, and program description are approved by the BCT QLC for implementation with final approval and endorsement by the BOD. The BCT QLC has been delegated by BCT's BOD to provide oversight of the BCT PHQIP and thus recommend approval of all related Population Health QI annual documents.

Provider data is shared with providers through various quality initiatives.

Data is available to providers and members through public information sources such as Comparative Analysis of Audited Results from the Division of TennCare MCOs published on the Division of TennCare website at https://www.tn.gov/tenncare/information-statistics/mco-quality-data.html

The National Association for Quality Assurance also publishes information on the health plan at https://reportcards.ncqa.org/health-plans.

Confidentiality and Conflict of Interest

BCT, 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). BCT 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 QI 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 BCT.

To better meet the needs of our customers, BCT promotes the delivery of medically necessary health services in a culturally appropriate, language appropriate and professionally competent manner to all Members, including those with limited English proficiency, diverse cultural and ethnic background as well as those with developmental and/or cognitive disabilities.

Services available:

- Language Line Solutions to offer language assistance to members, including over the phone interpreting with Direct Response to field inbound call volume for the most prevalent language
- Google Translate for all content
- All Spanish material content is available in a consolidated section, as well as the Find A Doc tool offers a Spanish translation feature
- Medically Qualified interpretation services
- Video Remote Interpreting, including American Sign Language
- Onsite Interpreting
- Personal Interpretation
- Hearing impaired - written supports as well as alternative formats including the BCT website
- Visually impaired - alternative formats including the BCT website, offers the capability to increase to 18 point font and key Member materials are available, including Braille, large print, and compact discs

Finally, BCT informs members of their rights to file complaints and to have them investigated without the threat of intimidation, retaliation, coercion or further discrimination. Grievances are tracked and trended and reported to the appropriate Committee structure. Based on complaint data, BCT monitors member experience with its services and identifies areas for potential improvement.

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 all BCT members, including CHOICES and Non-CHOICES members.

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
  - Any error of medication administration or documentation
  - Administration of incorrect drug, dose, route, rate, time, person
  - Incorrect Medication Administration Record (MAR) documentation
- 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

➢ Theft

- 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/forms/Provider%20Forms/HHCI-Form.pdf.

The completed form should be submitted to:

BlueCare Quality of Care Oversight Department

E-mail BlueCareQOC@bcbst.com

Fax: 1-855-339-3022 (if email is not available)

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 following numbers:

BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978

All allegations of abuse, neglect, and exploitation of an adult must report to APS via:

Phone:	1-888-277-8366
Electronic:	https://reportadultabuse.dhs.tn.gov/

All allegations of abuse, neglect, and exploitation of a child must report to CPS via:

Phone:	1-877-237-0004
Electronic:	https://carat.app.tn.gov/carat/

Death of Member

All unexpected deaths of BCT Members must be reported to BCT 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 BCT as quickly as possible upon discovery using the *Death of Member Notification Form* located online at

https://bluecare.bcbst.com/forms/Provider%20Forms/Member-Death-Notification-Form.pdf .

The completed form should be submitted to:

BlueCare Quality of Care Oversight Department

E-mail: BlueCareQOC@bcbst.com

Fax: 1-855-339-3022 (if email is not available)

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, email address, or call one of the numbers below:

BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978

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 Process 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.
3. 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.

B. The following actions must generally be reported:

1. 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.
2. 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.
3. A summary suspension that remains in effect for longer than fourteen (14) days.

C. Reports required by federal or state law, including without limitation the NPDB, must include:

1. the name of the Provider,
2. a description of the facts and circumstances that form the basis for that action, and
3. any other relevant information requested by that licensing board.
4. The following actions are generally not reportable:
5. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.
6. 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.

D. 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. Provider Agreement

All BlueCare, TennCare*Select* 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, TennCare*Select* and CoverKids plans. All provider agreements, contracts, or templates, and revisions thereto, must be approved in writing in advance by TDCI in accordance with statutes regarding the approval of a certificate of authority (COA) and any material modifications thereof. Provider agreements shall not contain covenant-not-to-compete requirements or terms requiring a provider to not provide services for any other TennCare MCO. Furthermore, BlueCare Tennessee shall not execute any provider agreements that contain compensation terms that discourage providers from serving any specific eligibility category or population covered by the CRA.

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.

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.

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.

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.

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.

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.

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.**

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.

Member Appeals/Grievances

If the service has NOT been rendered, providers can appeal on behalf of the member by written authorization. Providers must complete the form below which includes obtaining the member's signature https://www.tn.gov/content/dam/tn/tenncare/documents/medappeal.pdf.

Member appeals are submitted to TennCare by the following methods:

1. **Call**: Call TennCare at 1-800-878-3192. Monday through Friday during the hours 8 a.m. to 4:30 p.m., Central Time.
2. **Fax**: Fax the TennCare Medical Appeal form for free to 1-888-345-5575
3. **Mail**: Mail the TennCare Medical Form to:

   TennCare Member Medical Appeals
   P.O. Box 000593
   Nashville, TN 37202-0593

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 (HHS_OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), Social Security Death Master File (DMF) and TennCare's Terminated Provider List.

"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 and TennCare's Terminal Provider List on a monthly basis. In addition, the subcontractors shall screen their owners and employees against the Social Security Master Death File at least on an annual basis. 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.

Non-Medically Necessary Services

Members may not be billed for services that BlueCare Tennessee does not consider Medically Necessary.

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, TennCare*Select* and/or CoverKids Members.

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 Process set forth in this Manual (the "Provider Dispute Resolution Process") 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 TennCare & CoverKids[1] Programs Request to Commissioner for Independent Review of Disputed Provider Claim form is located on the state's website at <https://www.tn.gov/content/dam/tn/commerce/documents/tcoversight/forms/INDEPENDENT_REVIEW_REQUEST_FORM_TC_CK_IN2001_092921.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.

Provider Training

Provider agrees that Provider and its Associated Providers, as applicable, will participate in any required training provided by BCT that is necessary to ensure satisfaction of all BCT's responsibilities under the State Contracts.

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, TennCareSelect 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).

Regulatory Requirements

BCT and Provider will each comply with all applicable Regulatory Requirements. The failure to expressly reference a Regulatory Requirement applicable to either Party in connection with their duties and responsibilities hereunder will in no way limit such Party's obligation to comply with such Regulatory Requirement. Without limiting the foregoing, this reference incorporates all applicable federal law and state laws, TennCare rules and regulations, consent decrees and court orders. Any amendments to or revisions of such laws, regulations, consent decrees or court orders will automatically be incorporated as of their respective effective dates.

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.

A. Reconsideration (1st Level Appeal)

1. **Reconsideration (1st Level Appeal) Description**
   A Reconsideration is a Providers 1st Level Appeal for payment issues. Providers can submit a Reconsideration for review of non-clinical information about services already rendered. Since these inquiries are claims-oriented in nature, they may be submitted to the appropriate Regional Customer Service Center. Reconsiderations may be requested for the following reasons.

   - Timely filing
   - Contract Reimbursement
   - Medicaid ID/Disclosure
   - Post-Payment Audit
   - Third Party Liability
   - Code Bundling/Editing
   - PCP Denial

2. **How to submit Reconsiderations**
   Providers may submit a Reconsideration by calling the Provider Service Line (BlueCare 1-800-468-9736 or TennCare*Select* 1-800- 276-1978). The new Inquiry, Reconsiderations and Appeals Tool will be hard launched in Availity on 04/01/26. At that time, all providers will be required to submit their inquiries, reconsiderations, and appeals through Availity, and we will no longer accept these submissions by fax, mail, or email. Exhausting the above noted processes satisfies Section II. A and B. of the Provider Dispute Resolution Process (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 Process

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 Process 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.

G. 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 PROCESS.

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.

Provider Appeal Form

Additional information on Appeals and Reconsideration 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 TennCare*Select* (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, its authorized representative, Department of Disability and Aging (DDA), 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, Medicaid Fraud Control Division (TBI MFCD), 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 DDA, TN OIG, the TBI MFCD, 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.
19. Behavioral health Providers shall maintain medical records in conformity with Tenn. Code Ann. §33-3-101 et seq. for persons with serious emotional disturbance or mental illness.
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, DDA, the TN OIG, the TBI MFCD, 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 DDA, the TN OIG, the TBI MFCD, 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, DDA, TN OIG, TBI MFCD, 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.2.23.8 (Security and Information Security and Access Management Requirements) of the Agreement.

23. TENNCARE, DDA , DHHS OIG, Office of the Comptroller of the Treasury, OIG, TBI MFCD, 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, DDA, OIG, TBI MFCD, DHHS OIG and DOJ. Any authorized state or federal agency or entity, including, but not limited to TENNCARE, DDA, OIG, TBI MFCD, 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. All contracted and non-contracted providers, groups and facilities who participate in the BlueCare and TennCare*Select* networks and/or receive TennCare funds must comply with federal ownership disclosure requirements (42 CFR Part 455). These requirements also apply to referring, ordering and prescribing providers who serve TennCare members, even if they don't participate in BCT networks. According to the guidelines, providers must submit routine disclosures during initial contracting and at least every three years afterward. You may need to submit a disclosure sooner than three years if:
    - You renew your contract
    - Information on the disclosure form changes
    - There's a change of ownership

    In cases of change of ownership, the revised disclosure must be submitted within 35 business days. To satisfy these requirements, we encourage you to update your TennCare provider profile any time there are changes to your practice's office manager or others with an ownership stake in

your practice. This includes updating your information if someone associated with your practice is convicted of a crime. To change the information in your provider profile, visit tn.gov/tenncare/providers/provider-registration.html.

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), TennCare's Terminated Provider List, DMF and debarment (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, SCHIP, or any federal healthcare programs (as defined in Section 1128B(f) or 1156 of the Social Security Act) and 42 CFR 455.101 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 submit a written 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 and subcontractor shall conduct criminal background checks registry and exclusion checks, excluding checks against the Social Security Master Death File, in accordance with state law, rule, and TennCare policy and ensure that all employees, agents, subcontractors, providers, owners of provider agencies and managing employees or anyone acting for or on behalf of the MCO conducts criminal background checks and registry and exclusion checks in accordance with state law and TennCare policy. At a minimum, background checks, registry and exclusion checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National Sexual Offender Registry, TennCare's Terminated Provider List, SAM and List of Excluded Individuals/Entities (LEIE). Notwithstanding the above, providers are exempt from conducting registry checks of the Social Security Death Master File. The FEA shall be responsible for conducting background checks on its staff, its subcontractors, and consumer-directed workers. Criminal background checks, registry and exclusion checks must be performed and document in the worker's employment record or otherwise maintain these records on any employee or volunteer who will have direct contact with a Member in CHOICES or ECF CHOICES. All criminal background, registry and exclusion checks required in Section 2.29.2.2 of the Agreement must be completed prior to any such person having direct contact with a Member in CHOICES or ECF CHOICES. Any owner of a provider agency, managing employee, employee or volunteer supporting CHOICES or ECF CHOICES. Members who will not have direct contact with these Members, must have required background, registry and exclusion 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, registry or exclusion 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.2.9.6.6 of the Agreement and TennCare Rules 1200-13-01.05.

47. Provider is required to report suspected abuse, neglect, and exploitation of adults in accordance with Tenn. Code Ann. §71-6-103 and to report suspected brutality, abuse, or neglect of children in accordance with Tenn. Code Ann. §37-1-403 and Tenn. Code Ann. §37-1-605.
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; which allows the MCO to notify appropriate internal staff such as the member's Care/Support Coordinator. Hospitals, including psychiatric hospitals, shall cooperate with the MCO in developing and implementing protocols as part of the MCO's nursing facility and ICF/IID diversion plan (see Section A.2.9.7.7 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 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.
49. 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.
50. Except as otherwise specified in Sections A.2.12.10 or A.2.12.12 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*).
51. 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.
52. 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.).
53. 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 all applicable federal and state laws and regulations, including section 1902(kk)(8) of the Social Security Act under the Title XIX, Title XVIII, or Title XXI.
54. 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.
55. 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.

56. 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).
57. 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.
58. 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.
59. 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.
60. 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.
61. 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.
62. 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 E.6 of the Agreement.
63. Provider must comply with 42 CFR Part 438, Managed Care, including but not limited to 438.3, 438.6(f)(2)(i), compliance with the requirements mandating Provider identification of Provider-preventable conditions as a condition of payment for provider preventable condition as set forth

in 434.6(a)(12) and 447.26. At a minimum, this shall mean non-payment of Provider-preventable conditions as well as appropriate reporting as required by the MCO and TENNCARE.

64. 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.
65. 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.).
66. Provider agrees to coordinate with the TENNCARE Pharmacy Benefits Manager (PBM) regarding authorization and payment for pharmacy services.
67. Providers who participate in the federal 340B program shall give MCO the benefit of 340B pricing.
68. 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 Process.
69. 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.2.7.7.
70. 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.
71. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees.
72. 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.

    Providers and Subcontractors shall be interacting with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equal outcomes equity and eliminate bias with generating assessment results. The provider shall ensure that its staff members carrying out the terms of the provider agreement shall receive annual training on the provider entity's: policies on how to

deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The provider entity shall ensure that its new hires carrying out the terms of the provider agreement shall receive this training on the aforementioned policies and procedures within thirty (30) days of joining the entity's workforce.

73. Providers and Subcontractors shall provide instruction regarding the written procedure for the provision of free language and communication assistance services such as, interpreter and translation services and auxiliary aids or services to any member or their representative who needs such services. This instruction shall include a component on providing cultural and linguistically appropriate services ("CLAS") that must include training and education on the potential impact of linguistic and cultural barriers on utilization, quality, and satisfaction with care and how to deliver CLASs services appropriately during a service encounter.
74. Providers and Subcontractors shall have written procedures for the provision of language and communication assistance services to Members and/or Member's representatives. Language and communication assistance in alternative formats for any Member and/or Member's representative who needs such services, including but not limited to, Members with Limited English Proficiency (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 shall provide any discrimination complaint or request for a reasonable accommodation received relating to TennCare's services and activities within two (2) days of receipt to TennCare's Office of Civil Rights Compliance ("OCRC") at HCFA.Fairtreatment@tn.gov. The provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and reviews for requests for reasonable accommodations and to assist individuals in obtaining information on how they can report a complaint or request a reasonable accommodation that involves TennCare's services or activities by contacting OCRC. To satisfy this obligation the provider may direct the individual to OCRC's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, to call TennCare Connect at 855-259-0701, or to the member's MCO if the member needs assistance with filing a complaint or requesting a reasonable accommodation.
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, the CONTRACTOR and its Providers and Subcontractors that are providing services pursuant to this Contract 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 sex. This includes the CONTRACTOR 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. Electronic and Information Technology Accessibility Requirements: 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"), the Americans with Disabilities Act, and 45 C.F.R. pt. 92 (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 the most current W3C's Web Content Accessibility Guidelines ("WCAG") level AA or higher with a goal to transition to WCAG 3 level silver (For the W3C's guidelines see https://www.w3.org/WAI/standards-guidelines and Section 508 standards: https://www.access-board.gov/ict/)
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 a Provider Agreement that includes Ethical and Religious Directives when a provider has conscience and religious beliefs that prevents them from providing certain TennCare covered services due to those beliefs, 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 or its conscience and religious beliefs to MCO. This list shall be provided by the Provider to the CONTRACTOR prior to the start date of the provider agreement with the CONTRACTOR and thereafter at least sixty (60) days before implementing any policy to discontinue a covered service based on the Provider's conscience and religious beliefs and/or its Ethical and Religious Directives. The MCO shall furnish this list to TennCare, pursuant to Section 2.28.3.1 notating 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 or its conscience and religious beliefs.
    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. 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 ten (10) 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 TennCare*Select* 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 contracted providers and delivering employment services to CHOICES or ECF CHOICES Members obtain certification and training pursuant to TennCare guidance and as required for compliance in 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).

    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.

c. 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.
d. 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.
e. 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.

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.

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.

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 services including any home health and private duty nursing service, 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.

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).

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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 a life endangering physical condition arising from the pregnancy itself that would place the mother in danger of death. Abortions are a Covered Service only when all guidelines listed below are met.

- A Certification of Medical Necessity for Abortion form must be correctly completed with the following:

(Except where noted, response may be typed or handwritten)

- *Date of Service: The date the abortion was performed;
- *Patient's Full Name;
- *Patient's Date of Birth;
- *Patient Address: The Member's complete address including street, city, state, and zip code;
- *Condition: Mark the block indicating the applicable reason for the abortion;
- *Supporting Documentation: Mark the block that applies to the type of supporting documentation;
- *Physician's NPI# and Address: The Physician's NPI# and complete address including street, city, state, and zip code; and
- *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.**

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, dated 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 lifesaving nature of the abortion must be submitted with the claim.*

- 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., spinabifida 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/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html.

B. Sterilization

BlueCare Tennessee covers sterilization pursuant to applicable federal and state laws and regulations. Sterilization is a Covered Service only when all 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.
5. In the case of delivery prior to the estimated due date, the consent form must have been signed by the Member at least 30 days before the expected date of the individual's delivery and there must be at least 72 hours between the date the Member signed the consent and the date of the surgery. In the case of emergency abdominal surgery (including medically indicated Cesarean section) there must be at least 72 hours between the date the Member signed the consent and the date of surgery.
6. The consent form expires 180 calendar days from the date of Member's signature.
7. The correctly completed sterilization consent form must be completed and attached to the claim when submitted for reimbursement.
8. Operative report should be attached to the claim.
9. Physician must sign line 21 on or after the date the sterilization was performed. A signature stamp or computer generated (electronic) signature is **not** acceptable.
10. When an interpreter is used, the interpreter's signature date may be the same as or earlier than the recipient's signature date. If the interpreter signs ***after*** the recipient, a 30-day waiting period will begin on the day following the interpreter's signature date. When interpretation is provided via teleconference, the individual obtaining the consent should document:

    a. The interpreter's name and ID number (if applicable)
    b. The method used (phone or video)
    c. Their own initials and the date the information was recorded

Federal law requires a valid consent form for sterilization procedures. The form should be properly completed and signed. If the form is altered, it becomes invalid.

Sterilization Consent forms are located on the U.S. Department of Health and Human Services (HHS) website at Key Resources for Title X Grant Recipients | HHS Office of Population Affairs, and Instructions for completing the sterilization consent form are found at https://www.tn.gov/content/dam/tn/tenncare/documents/sterilizationconsentform.pdf.

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:

- The hysterectomy is Medically Necessary.
- 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 <u>Not</u> 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.

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/tenncare-provider-news-notices-forms/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 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 indicate an abortion, sterilization, or hysterectomy was performed must also include the required documentation referenced above.
- 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.)

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XIV. Preventive Care

A. Prevention and Wellness

BlueCare Tennessee (BCT) 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 members thirty-five (35) to forty (40) years of age
- A yearly mammogram for members thirty-five (35) to forty (40) years of age if the member is at high risk based on personal family medical history, dense breast tissue, or additional factors that may increase the individual's risk of breast cancer;
- A yearly mammogram for members forty (40) years of age or older based on the recommendation of the member's physician.

BCT 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 members who are up to twenty-nine (29) years of age and older if the screening test is determined to be Medically Necessary.

BCT provides coverage for Cervical Cancer screening in accordance with guidelines from the American College of Obstetricians and Gynecologists (ACOG). Individuals with a cervix initiate cervical cancer screening every 3 years with cervical cytology alone in members aged 21 to 29 years. For members aged 30 to 65 years, ACOG recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papilloma virus (HPV) testing alone, or every 5 years with (HPV) testing in combination with cytology (co-testing). Cervical Cancer screening is not recommended for members with history of hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer. It is also not recommended for members older than 65 years who have had adequate negative prior screening and are not otherwise at high risk for cervical cancer. Updated Cervical Cancer Screening Guidelines | ACOG

BCT maintains internal tracking systems that identify current well-care and preventive services screening status and pending screening due dates for each member.

Telephonic, mailed, digital and Web-based reminders promote awareness and emphasize the importance of well-care and recommended preventive screenings, tests, and examinations.

The TennCare Contractor Risk Agreement (CRA) and TennCare*Select* Agreement (TSA) require that the Managed Care Organization (MCO) develop services and participate 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, BCT Clinical Quality Improvement (CQI), in collaboration with Member Education and Outreach, 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 Healthcare Effectiveness Data and Information Set (HEDIS®)

Preventive reminders and health promotion messages are disseminated through various avenues including, but not limited to:

- Interactive Call Outreach
- Member Health Planner – (A "traffic light" system is utilized to indicate the status of each screening/test – green for complete and on track, red for outstanding/past due).

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

- Postcards, brochures, or newsletters
- BCT website and social media (Facebook page and Instagram)
- Digital outreach, including text and digital care management
- Member, Provider and Community outreach activities
- Population Health activities

Content of educational brochures, postcards, and wellness/preventive reminder scripts is reviewed at least annually and revised as needed to ensure that the verbiage agrees with current evidence-based information, nationally recognized guidelines, regulatory guidelines such as EPSDT, and is consistent with other developed materials. 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 & Prevention, U.S. Preventive Services Task Force, National Institutes of Health, and Substance Abuse and Mental Health Services.

Telephonic, digital, and mailed outreach campaigns provide education and health promotion messages to members in appropriate age bands, which are relevant to their health risk and conditions.

Campaign content (telephonic reminder scripts 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.

Provider Outreach

- Educational brochures and toolkits are developed and distributed through face-to-face visits, email and are available on BCBST and BCT 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 Provider and Community Outreach Population Health Management and/or a Clinical Team.

HEDIS® Effectiveness of Care Access/Availability of Care, and Utilization measures are used to assess Member outcomes and effectiveness of activities.

B. Preventive Care Guidelines

BCT 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, BCT 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.

BCT 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 a Clinical Advisory Panel.

BCT 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 publication listed above, along with additional Preventive Services information, can be viewed via the following link, Manuals, Policies & Guidelines | BCBS of Tennessee (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 the BCT website, Your Health | BlueCare Tennessee (bcbst.com) and via 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 BCT requirements for Primary Care Providers (PCPs) in administering immunizations and providing periodic health assessment for BCT members.
2. Raise the overall immunization levels of BCT 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 BCT to monitor immunization levels and provide the PCP with feedback related to BCT member immunization programs. Preventive care responsibilities are shared by the member, his or her PCP, and BCT. The following outlines specific responsibilities:

Member Responsibilities

- Advise PCP of previous immunizations (re-advise whenever a new PCP relationship is established);
- 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. BCT 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 BCT members with the 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 on a specific preventive care form, in office notes, in a memo, or in a letter faxed or mailed 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 from 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 are eligible for the Vaccines for Children (VFC) Program 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.

BCT 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 administration.

The Recommended Childhood Immunization Schedule, approved by 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.

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 BCT 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 BCT's CQI Program, clinical indicators related to required medical record keeping practices, 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

BCT 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 PCP. Guidelines can be found at https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P.

Aged and Frail Elderly

BCT 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 and 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, and addictions, with 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 indicated.

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.

Special Counseling - Health habits, lifestyle issues, injury prevention, dental health, nutrition, etc.

Immunizations – Refer to the CDC 2025 Adult Immunization Schedule at https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/past/2025-adult.pdf

*See pap smear recommendations within the "Prevention and Wellness" section of this document.

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.

*Individuals with a cervix initiate cervical cancer screening every 3 years with cervical cytology alone in members aged 21 to 29 years. For members aged 30 to 65 years, ACOG recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papilloma virus (HPV) testing alone, or every 5 years with HPV testing in combination with cytology (co-testing). Cervical Cancer screening is not recommended for members with history of hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer. It is also not recommended for members older than 65 years who have had adequate negative prior screening and are not otherwise at high risk for cervical cancer. Members should still go to the doctor regularly for a checkup.

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 the CDC 2025 Adult Immunization Schedule at https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/past/2025-adult.pdf

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, glaucoma testing, and estrogen replacement.

Immunizations - Refer to the CDC 2025 Adult Immunization Schedule at https://www.cdc.gov/vaccines/hcp/imz-schedules/downloads/past/2025-adult.pdf

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. BCT 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.

New Patient

99381	Initial Evaluation	99385	Age 18 Thru 39
99382	Age 1 Thru 4	99386	Age 40 Thru 64
99383	Age 5 Thru 11	99387	Age 65 And Over
99384	Age 12 Thru 17		

Established Patient

99391	Periodic Reevaluation	99395	Age 18 Thru 39
99392	Age 1 Thru 4	99396	Age 40 Thru 64
99393	Age 5 Thru 11	99397	Age 65 And Over
99394	Age 12 Thru 17		

Prenatal Care

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59410	Vaginal delivery only (with or without episiotomy, and/or forceps) including postpartum care
59430	Postpartum care only (separate procedure)
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59515	Cesarean delivery only including postpartum care

Note: Please see Section V. Billing and Reimbursement – OB/GYN Services in the manual for additional billing instructions.

Counseling and/or Risk Factor Reduction Intervention

Individual		**Group**	
99401	~15 Minutes	99411	~30 Minutes
99402	~30 Minutes	99412	~60 Minutes
99403	~45 Minutes		
99404	~60 Minutes		

Other Preventive Services

77055; 77056; 77057	Mammography Screening
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	Administration of caregiver-focused health risk assessment (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.

92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
Additional preventive services may include age-appropriate recommended immunizations, laboratory testing, or procedures.	

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 VFC vaccines. These vaccines are available to any Provider who serves eligible Members.

If you provide care for BCT 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.

BCT 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 19 diseases listed below; to be administered as provided in other VFC resolutions:

COVID-19	Diphtheria	Human Papillomavirus	Mumps	Rotavirus
Dengue	Haemophilus influenza type b	Influenza	Pertussis (whooping cough)	Rubella
RSV	Hepatitis A	Measles	Pneumococcal	Tetanus
	Hepatitis B	Meningococcal	Poliomyelitis	Varicella

More information about the VFC program is found on the Centers for Disease Control and Prevention website at https://cdc.gov/vaccines/programs/vfc/index.html

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, BCT 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 VFC 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 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.

Beginning August 2019, BlueCare made a change to help address the needs of members age 18 years and under who are pregnant. Since OB/GYNs do not typically participate in the VFC program, they are not eligible to receive free vaccines from the Department of Health. Effective 8/1/19, BCT began reimbursing the influenza and Tdap vaccines for OB/GYN Providers. Effective 1/1/25, Advanced Practice Midwives will also be reimbursed for these vaccines. Effective 1/1/26, the RSV vaccine will be reimbursed for both OB/GYNs and Advanced Practice Midwives. Claims for these services will be paid outside of the VFC process and these Providers will receive the standard fee schedule for both the vaccine and the administration charges.

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:

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 the Division of 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 on 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
- Childcare 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, 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 needs 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, drugs, and other health damaging behaviors
- Hygiene
- First aid
- Childcare 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 completed during the visit
- Clinical findings of the visit
- Physical, sexual, and emotional — growth and development, appropriate to age and gender
- 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

The Division of TennCare has expanded dental benefits for patients with Medicaid coverage. As of Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage have dental benefits. Members under age 21 should receive dental services as part of their TennCare Kids screenings 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. (See Section XX. TennCare Kids in this Manual.)

Dental benefits are managed by the state's contracted dental benefits manager, Renaissance. For more information, please contact Renaissance Customer Service at **1-866-864-2526**.

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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 (Non-licensed Master's level, Psychiatric Technicians, Registered Behavior Technicians, etc.), 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 crisis 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 youth as well as home and community treatment for adults.

B. Covered Behavioral Health Services

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 TennCare*Select* Members:

Service	Benefit Limit/Requirements
Psychiatric inpatient hospital services (including physician services)	As Medically Necessary.

Service	Benefit Limit/Requirements
24-Hour psychiatric residential treatment services	Medicaid/Standard Eligible, age 21 and older: as Medically Necessary. Medicaid/Standard Eligible, Under age 21 years: as Medically Necessary.
Outpatient mental health services (including physician services)	As Medically Necessary.
Behavioral Health Intensive Community-Based Treatment *[1]	As Medically Necessary.
Psychiatric rehabilitation services *[1]	As Medically Necessary.
Behavioral health crisis services	As Necessary.
Lab and X-ray services	As Medically Necessary.
Non-emergency medical transportation*[1] (including non-emergency ambulance transportation)	As necessary to get an enrollee to and from Covered Services.
Inpatient, residential & outpatient substance use disorder benefits. *[2]	Medicaid/Standard Eligible, Age 21 and older: As Medically Necessary Medicaid/Standard Eligible, Under age 21: Covered as Medically Necessary. If Residential Substance Use Disorder Treatment provided in an Institution for Mental Disease for Age 18-64 is subject to a limited benefit.

1. Population Health Management

The entire BlueCare Tennessee, TennCare*Select*, and CoverKids enrollee population, including nonCHOICES members, CHOICES members, I/DD MLTSS (Intellectual/Development Disability Managed LongTerm Services and Supports) members, dual-eligible CHOICES members, and dual-eligible I/DD MLTSS members are enrolled in the Population Health Management Program. Members are identified and placed in specific Population Health cohorts across the entire care continuum – including low-or no-risk level, rising risks and high risks. Members receive outreach and support from their integrated care team according to their placement.

Additional information on our Population Health Management program can be found in Section X. Population Health Management of this Manual.

2. Care Management and Member Outreach

BlueCare's Care Management staff connect members to services that assist them in self-managing their health, accessing needed care, and connecting with providers and community resources. Cohort content and interventions are based on documented objectives, member assessments and risk stratification. Population Health activities, interventions, and education objectives vary for each cohort, with increasing engagement

* 1 For CoverKids Members, PACT, Psychiatric Rehabilitation Services, and Non-emergency medical transportation are not covered benefits.

* 2.When Medically Appropriate, services in an Institution for Mental Disease Substance Use Disorder Residential Treatment Center facility are subject to a 30-day benefit over a rolling 12 months. This service requires pre-authorization. Institution for Mental Disease Substance Use Disorder Residential Treatment Center facility is defined as a facility with 16 or more beds that provides diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services, including Medication Assisted Treatment services.

and intensity as the member's level of risk increases This cohort approach includes four **activities and interventions**:

1. Helping healthy individuals stay healthy, including clinical reminders around preventative care
2. Helping Members manage their own health risk
3. Helping individuals with complex health problems better manage their condition
4. Integration with CHOICES and I/DD MLTSS Programs

3. 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://provider.bcbst.com/working-with-us/behavioral-health

Effective January 1, 2015, BlueCare Tennessee adopted MCG and modified MCG guidelines. These guidelines can be referenced at:

https://www.bcbst.com/providers/UM_Guidelines/lc-psych.htm

MCG Cite Guidelines

4. Frequently Asked Questions – Mobile Crisis

Providers may reference TN Division of TennCare's "Frequently Asked Questions" regarding : Mobile Crisis, Emergency Involuntary Admission Process, Mandatory Pre-screening Agents, and Crisis Stabilization Unit.

https://www.tn.gov/content/dam/tn/mentalhealth/documents/FAQs_Psychiatric_Crisis_Delivery_System_April_25_2017.pdf

Note: Mobile Crisis assessment are to be completed for the following level(s) of care: Psychiatric Inpatient.

5. 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 exists 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.

6. 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.

7. 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.

8. 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.

9. 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. Information regarding screening tools are available at: https://provider.bcbst.com/working-with-us/behavioral-health);
- 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.

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.
- Behavioral Health Services Furnished by Candidates for Licensure: https://www.tn.gov/content/dam/tn/tenncare/documents2/pro-22-002.pdf

➢ A qualified graduate student must be supervised by an independently licensed professional that is enrolled under the entity contracted with BlueCare. The primary supervising professional must be present and practicing at the same licensed facility at which the qualified graduate student is practicing, and must be available for consultation in case of an emergency. If the primary supervising professional is absent, another qualified supervisor must be present and available for consultation. Please see TennCare policy for full requirements:

- Behavioral Health Services Furnished by Qualified Graduate Students: https://www.tn.gov/content/dam/tn/tenncare/documents2/pro-22-001.pdf
  - 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.

10. 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.

11. 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 TennCare*Select* case manager, the community care coordinator, all outpatient Providers, and the inpatient team.

12. 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.

*THL services are not a covered benefit for CoverKids Members.

13. Prior Authorizations

Psychological and Neuropsychological testing, 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 Substance Use Disorder 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. **Note**: Effective July 1, 2024, Electroconvulsive Therapy no longer requires prior 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 or complete.

Authorization requests for urgent inpatient behavioral health services need to be submitted within twenty-four (24) hours of admission or the next business day.

Authorization requests for elective inpatient behavioral health services like residential treatment and any outpatient service requiring prior authorization should be submitted twenty-four (24) hours prior to admission, but no later than one (1) business day after admission.

Providers can submit requests by telephone, mail or the Web through Availity at https://apps.availity.com/availity/web/public.elegant.login

Prior authorization requests for behavioral health services may be submitted via fax to 1-800-292-5311 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 TennCare*Select*.

Note: Prior authorization requests for behavioral health services for CoverKids should continue to be submitted via fax to 1-800-292-5311 or by calling the Provider Service Line at 1-800-924-7141.

Mail requests to:

BlueCare/TennCare*Select*
UM Support, CH 4.3
1 Cameron Hill Circle
Chattanooga, TN 37402

14. 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.

Effective 10/20/2025, TennCare changed the notification process for adults (aged 21 and older) related to Inpatient, Subacute and RTC discharges. This process change was designed to foster real-time discharges, when medically appropriate, and to ease the administrative burden for the providers. This updated process requires the provider to issue a Same Day Notification (SDN) to the member in real-time, as part of the discharge process, this will include their appeal rights. This updated process removes administrative burden by removing the two-business day notification previously required.

Also effective 10/20/25, PIN notices are no longer required for any outpatient services.

For ages 21 and above:

The SDN letter is a standard notice for all 3 MCOs that includes appeal rights and requires a signature from the member certifying receipt. The signed SDN letter will be returned to the MCO with the discharge summary within one business day of discharge. The discharge summary must indicate the MD who made the recommendation to stop care. The signed SDN letter and discharge summary should be sent to the designated discharge fax number for each individual MCO. The SDN letter should not be sent to the designated PIN fax number: https://bluecare.bcbst.com/providers/tools-resources/documents-forms.

For ages 0-20:

The Division of TennCare requires that all members ages 0-20 being discharged from inpatient psychiatric acute, inpatient detox, psychiatric residential, and substance use disorder residential, 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 at http://bluecare.bcbst.com/forms/Provider%20Forms/Provider_Initiated_Notice-Adverse_Action.pdf.

Submit PINs by fax to 1-800-859-2922. PIN may also be uploaded as an update to the member's record on Availity.

15. Levels of Service

Providers of behavioral health services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of behavioral health services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards. All applicable Tennessee state mandated requirements of the Tenn. Code Ann. § 56-7-2367 (2016) 56-7-2367 for Autism Spectrum Disorders are also followed by BlueCross BlueShield of Tennessee.

Additional resources that provide specific treatment expectations and best practices can be found below:

https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-45.20081110.pdf

MCG Cite Guideline Transparency

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 and 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. Effective 10/1/22, members utilizing this service are excluded from participation in THL for the duration of their treatment within this level of care.

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. Effective 10/1/22, members utilizing this service are excluded from participation in THL for the duration of their treatment within this level of care.

Specialized Comprehensive Child and Family Treatment (SCCFT)

SCCFT provides a team approach for treating children and youth with intellectual and developmental disabilities and co-occurring emotional and/or behavioral problems who are at high risk for hospitalization or placement out of the home. SCCFT services are high intensity, goal-specific services designed to provide stabilization and deter the imminent risk of out of home placement, including state custody or higher levels of care, while providing individualized support services to the youth and/or family. Services will also address the youth's needs for accommodations across all systems to promote their health, safety, stability, and well-being, as well as assist in identifying, locating, and accessing supports and services.

SCCFT services concentrate on child/family/guardian behaviors and interactions with the goal of reaching an appropriate point of stabilization so the individual can transition to a less intensive outpatient service. SCCFT services can be provided in home, community, school, or office-based settings with the youth and family using a frequency appropriate for the intensity and imminent risk presented by the clinical situation. Typically, at least three to five sessions a week will be offered depending on family need. SCCFT services are available 24 hours a day and seven days a week and include on-call crisis support.

Specialized Comprehensive Treatment Teams (SCTT)

SCTT are specialized multi-interdisciplinary teams that provide a range of intensive, integrated mental health care coordination, treatment, and rehabilitation services to adolescents and adults (12 and above) with Intellectual and/or Developmental disability and co-occurring behavioral health conditions, display severe dysfunction in daily living, have exhibited an increase in behavioral incidents over the past 30 days, and are showing a significant change in school, home, or community functioning. SCTT is designed to provide flexible, multi-purpose, community-based clinical support for adolescents and adults. Interventions are aimed toward the adolescent or adult and his/ her family and/or paid caregivers when appropriate in order to provide stability and preservation in the community setting. SCTT services address the unique needs of each member with attention given to cultural values and individual/family strengths and are available for in person intervention 24/7 as clinically appropriate.

Intensive Care Coordination (ICC)

ICC is a service that facilitates care planning and coordination of services for TennCare youth, with serious emotional disturbance (SED), under the ag e of 21. Care planning is driven by the needs of the youth and developed through a Wraparound-inspired planning process based upon the Systems of Care philosophy. Intensive Care Coordination (ICC) provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner. Services and supports, which are guided by the needs of the youth, are developed through an ICC team planning process consistent with Systems of Care philosophy that results in an individualized and flexible plan of care for the youth and family. ICC is designed to facilitate a collaborative relationship among a youth with SED, his/her family and involved child-serving systems to support the parent/caregiver in meeting their youth's needs. The ICC care planning process ensures that a care coordinator organizes and matches care across providers and child serving systems to enable the youth to be served in their home community.

Program of Assertive and Community Treatment (PACT)

(Does not apply to CoverKids)

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.

Infant and Early Childhood Mental Health (IECMH)

Infant and Early Childhood Mental Health services focus on the need to ensure that all babies and young children have a strong beginning in life. During the first five years of life, emotionally nourishing relationships support children's well-being and lay the foundation for lifelong health and well-being. By supporting the infants, young children, and the adult caregivers, we hope to maximize our long-term impact in ensuring all young children have a bright future.

Infant and Early Childhood Mental Health (IECMH) refers to the social-emotional well-being of children ages 0 through five years of age (72 months). A central tenet is that infant development cannot be separated from the caregiving environment, nor can infant development be separated from the culture in which the relationships develop. IECMH includes:

- The ability to form close and secure relationships.
- The developing capacity of the child to experience, regulate, and express emotions; and
- The ability to explore the environment and learn.

The physical, cognitive, social, and emotional capacities of the child are mediated by the quality of the caregiver-child relationships. Similarly, the relationships between the mental health practitioner, the child, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.). The need for IECMH assessment and intervention could be identified/referred by any community provider.

Tennessee Health Link (THL)

(Does not apply to CoverKids)

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.

Effective 10/1/22, members utilizing CTT/CCFT are excluded from participation in THL for the duration of CTT/CCFT treatment.

Effective 7/1/25, members utilizing ICC (Intensive Care Coordination) are excluded from participation in THL for the duration of ICC treatment.

Effective 1/1/26, members utilizing SCTT (Specialized Community Treatment Team) are excluded from participation in THL for the duration of SCTT treatment.

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

(Does not apply to CoverKids)

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.

1. Service Components

Services for adults (age 18 and up) 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 and 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/TennCare*Select* 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/tools-resources/documents-forms.

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.

Authorization requests for elective inpatient behavioral health services, like residential treatment, should be submitted twenty-four (24) hours prior to admission, but no later than one (1) business day after admission.

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/TennCare*Select* 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 Tennessee **Fax**: 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 staff with device specific training and performed under the supervision of a licensed and trained Psychiatrist. The supervising Psychiatrist must be available on site or readily available.

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.

The following CPT® codes are used for billing TMS services:

90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

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. Buprenorphine Enhanced and Supportive Medication Assisted Recovery and 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 implemented a new coding and reimbursement structure for Buprenorphine Medication Assisted Treatment (BMAT) services, now known as Buprenorphine Enhanced and Supportive Medication Assisted Recovery and Treatment (BESMART).

Codes are not restricted to behavioral health prescribers and can be utilized by any in-network prescriber with the appropriate waiver to render Buprenorphine Medication Assisted Recovery and Treatment (BESMART) services, including any Nurse Practitioner or Physician Assistant who meets criteria outlined by PC 771, PC 761, and PC 857 who has been accepted by BCBST to be added to the BESMART program and who also agrees to the BESMART Amendment by Notification by completing, signing and returning the Data Verification Form for Recognition and Reimbursement as a 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 BESMART services:

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Service	Code	Mod -ifier	HCPCS Description	BMAT Specific Description	Mode of Reimburse-ment	Licensure/ Certification Considerations	Additional Information
Outpatient BMAT – Induction/ Stabilization Phase	H0014	HG	Alcohol and/or drug services; ambulatory detoxification	Alcohol and/or drug services; ambulatory detoxification - Buprenorphine induction (approx. 60 minutes)	Alcohol and/or drug services; ambulatory detoxification – Buprenorphine induction (approx. 60 minutes)	Network Eligible Buprenorphine prescriber	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
Outpatient BMAT – Maintenance Phase	H0016	HG	Alcohol and/or drug services; medical/ somatic (medical intervention in ambulatory setting	Buprenorphine services in ambulatory setting – includes therapy required by BMAT Program Description and being provided by mental health professional practicing within scope of licensure	One billable encounter per day, both services delivered same day *1	Network Eligible Buprenorphine prescriber and in-network mental health professional (if prescriber is not a psychiatrist/ addictionologist) . See BMAT Program Description for more information	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

[1] As communicated during the PHE and until notified otherwise, BlueCare will continue to allow counseling on a different DOS when clearly documented and directly corresponding to the prescriber DOS. Ideally, for auditing purposes, the two components should occur within two to seven days.

Service	Code	Mod -ifier	HCPCS Description	BMAT Specific Description	Mode of Reimburse-ment	Licensure/ Certification Considerations	Additional Information
							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
Outpatient BMAT – Maintenance Phase	H0033	HG	Oral medication administration, direct observation	Oral medication administration, direct observation (ongoing Buprenorphine services, following Induction Phase)	One billable encounter per day	Network Eligible Buprenorphine prescriber	This code is to be used in lieu of (not in addition to) Evaluation and Management codes and excludes counseling/ therapy. This code should be used when counseling/ therapy is not provided on the same day as prescriber services and/or is being billed separately by an in-network mental health professional with whom prescriber has a collaborative agreement and appropriate release for exchange of information. While there is no prior authorization required to bill using this code, there may be authorization requirements specific to Buprenorphine

H. Methadone Medication Assisted Treatment

Effective June 1, 2020, credentialed and contracted Opioid Treatment Programs can provide Medication Assisted Treatment for Opioid Use Disorder. Billing codes with descriptions and rates can be found at https://www.tn.gov/content/dam/tn/tenncare/documents/MethadoneBillingInformation.pdf

I. Neuropsychological and Psychological Testing

Check member benefits for prior authorization requirements. The following codes were developed by the APA and AMA. **Note:** As a reminder, neuropsychological testing is a medical benefit. A listing and description follow:

CPT® Code	Units	Description
96130	1	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	1	Each additional hour (List separately in addition to code for primary procedure)
96132	1	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	1	Each additional hour (List separately in addition to code for primary procedure)
96136	1	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137	1	Each additional 30 minutes (List separately in addition to code for primary procedure)
96138	1	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	1	Each additional 30 minutes (List separately in addition to code for primary procedure)

For psychologists using Licensed Psychological Examiners (LPE), these practitioners require supervision according to their state licensure. If the actual provider of the service needs the direction or supervision of a psychologist to legally perform the service and is ineligible to bill under their own NPI pursuant to the terms and conditions of their license or certification, then such supervising practitioner will be allowed to bill those services under their name and NPI. Supervising practitioners must perform all requirements and follow all regulations set forth by the applicable medical licensing or certification board for this specialty.

Single-Psychological or Neuropsychological Automated Test with Automated Result

No prior authorization is required when billing for this service. A listing and description follow:

CPT® Code	Description
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.

J. Applied Behavior Analysis (ABA)

ABA is an approved treatment modality and has a significant focus on identifying the function of unwanted behavior and development and implementation of a structured treatment plan to decrease undesirable behaviors and increase desirable behaviors. ABA is not: psychological testing, neuropsychology, psychotherapy, cognitive therapy, psychoanalysis, hypnotherapy or long-term counseling.

ABA Providers using Registered Behavior Therapists (RBT) are expected to demonstrate compliance with the supervision guidelines outlined by the Behavior Analyst Certification Board, Inc. ® (BACB®) located at https://www.bacb.com/wp-content/uploads/2020/05/RBTHandbook_201124.pdf .

When the Board Certified/Licensed BCBA is physically present with the Member (with or without the Registered Behavior Technician (RBT) being present) then the procedure code for the claim would be the applicable service the BCBA provides. If the RBT was alone with the Member carrying out the service plan, then the code would be for the applicable service the RBT provides.

The RBT service codes can be utilized by Registered Behavior Technicians, Board Certified Assistant Behavior Analysts (BCaBA) or by a Provider who has completed their training in Applied Behavior Analysis and is waiting to take the exam to become a Board Certified Behavior Analyst (BCBA).

Please note that TennCare does not allow immediate family members to receive reimbursement for covered services including ABA. This includes services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse's parents or stepparents, or members of the recipient's household.

https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20230419.pdf

Providers should bill in a manner consistent with the CPT code descriptions. In addition, if the BCBA is directing an RBT, the client is present, and one or more protocols have been modified then 97155 may be billed concurrently with the RBT codes.

2019 CPT® Code	2019 Duration	Description
0362T	per 15 minutes	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: ➢ administered by the physician or other qualified healthcare professional who is on site; ➢ with the assistance of two or more technicians; ➢ for a patient who exhibits destructive behavior; ➢ completed in an environment that is customized to the patient's behavior.
0373T	per 15 minutes	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: ➢ Administered by the physician or other qualified healthcare professional who is on site ➢ with the assistance of two or more technicians ➢ for a patient who exhibits destructive behavior ➢ an environment that is customized to the patient's behavior
97151	per 15 minutes	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
97152	per 15 minutes	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute.
97153	per 15 minutes	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes
97153HO	per 15 minutes	Adaptive behavior treatment by protocol, administered by a Physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes (effective for dates of service 9/1/2019 and forward)

2019 CPT® Code	2019 Duration	Description
97154	per 15 minutes	Group adaptive behavior treatment by protocol; administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes
97155	per 15 minutes	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.
97156	per 15 minutes	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregivers, each 15 minutes
97157	per 15 minutes	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	per 15 minutes	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes

K. 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 Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) 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:

Service Type	Geographic Access Requirement for the Service	Maximum Time for Admission/Appointment
Psychiatric Inpatient Hospital Services	Transport access <90 miles travel distance and <120 minutes travel time for all CHILD and ADULT Members	4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)
24-Hour Psychiatric Residential Treatment	Not subject to geographic access standards	Within 30 Calendar days
Outpatient Non-MD Services	Transport access <30 miles travel distance and <45 minutes travel time for at least 75% of CHILD and ADULT Members and <60 miles travel distance and <60 minutes travel time for all CHILD and Adult Members.	Within 10 business days; if urgent, within 48 hours
Intensive Outpatient (May include Day Treatment (adult), Intensive Day Treatment (Children & Adolescent) or Partial Hospitalization	Transport access <90 miles travel distance and <90 minutes travel time for 75% of CHILD and ADULT Members and <120 miles travel distance and <120 minutes travel time for all CHILD and ADULT Members.	Within 10 business days; if urgent, within 48 hours
Inpatient Facility Services (Substance Use)	Transport access <90 miles travel distance and <120 minutes travel time for all CHILD and ADULT Members	Within 2 calendar days; for detoxification-within 4 hours in an emergency and 24 hours for non-emergency
24 Hour Residential Treatment Services (Substance Use)	Not subject to geographic access standards.	Within 10 business days

Service Type	Geographic Access Requirement for the Service	Maximum Time for Admission/Appointment
Outpatient Treatment Services (Substance Use)	Transport access <30 miles travel distance and <30 minutes travel time for 75% of CHILD and ADULT Members and <45 miles travel distance and <45 minutes travel time for all CHILD and ADULT Members.	Within 10 business days; for detoxification-within 24 hours
Intensive Community-Based Treatment Services	Not subject to geographic access standards	Within 7 Calendar days
Tennessee Health Link Services	Not subject to geographic access standards	Within 30 Calendar days
Psychosocial Rehabilitation: (may include Supported Employment, Illness Management & Recovery, Peer Recovery Services, or Family Support service)	Not subject to geographic access standards	Within 10 business days
Supported Housing	Not subject to geographic access standards	Within 30 calendar days
Crisis Services (Mobile)	Not subject to geographic access standards	Face-to-face contact within 2 hours for emergency situations and 4 hours for urgent situations
Crisis Stabilization	Not subject to geographic access standards	Within 4 hours of referral

Medical and Behavioral Health

Emergency Care for Adult and Child Standard

Immediate evaluation by an appropriate provider – these services may be provided by facility-based providers. Emergency Care is 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 reasonably result in the following: serious impairment of bodily functions, serious dysfunction of any body organ or part, could reasonably be expected to place the person's health in serious jeopardy; threat to the health and safety of a pregnant woman who is having contractions or to an unborn child; danger to self (including psychiatric conditions and intoxication). It is understood that in those instances where a physician makes emergency care determinations, the physician shall use the skill and judgement of a reasonable physician in making such determinations.

Member Access to Behavioral Health Care

Appointment Type: Non-Life-Threatening Emergency

Standard: Within six (6) hours

Definition – Non-Life-Threatening Emergency - An emergency situation where clinical evidence shows that a person requires immediate care, but that lack of care would not lead to death

Appointment Type: Urgent Care

Standard: Within 48 hours

Appointment Type: Initial Visit for Routine Care

Standard: Within 10 business days

Definition - Initial Visit for Routine Care - Does not include follow-up care for an existing problem

Appointment Type: Follow-up Routine Care

Standard: Within 10 business days for non-prescriber and within 30 business days for prescriber

Definition – Follow-up Routine Care - Visits at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit, within clinically reasonable timeframes

Appointment Type: After-Hours Care:

For after-hours phone calls where the member leaves a message with an answering service/machine, the provider or their designated call coverage provider (unless otherwise approved by BlueCross, the call coverage provider shall be a BlueCross participating provider) will return the phone call to the member within the following time frames:

- In less than or equal to 30 minutes from when the member calls and leaves a message for urgent calls; and
- In less than or equal to 90 minutes from when the member calls and leaves a message for routine calls

Seven-day; 24-hour coverage through participating providers required for all networks. BlueCross may ensure compliance by calling provider's offices after hours to see if return phone calls are received within the above time frames.

Treatment Access to Facilities and Professionals

BlueCare Tennessee maintains standards to provide access to licensed and approved psychiatric and substance use disorder facilities and treatment programs, as well as licensed behavioral health care professionals.

Facilities must be licensed by the State and may require accreditation by the Joint Commission or the Commission Accreditation of Rehabilitation Facilities, or other recognized accrediting body to be approved for network participation.

Behavioral health care professionals must be state-licensed at the independent practice level in the state in which the services are provided and meet other requirements as formulated by State of Tennessee law, BlueCross BlueShield of Tennessee, and the behavioral health services covered under the member's health care plan:

Additional details regarding network eligibility requirements can be found in Section XVII- Credentialing, in this Manual.

L. Behavioral Health Quality of Care and Adverse Occurrences

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. These will be reviewed per BlueCross Clinical Risk Management (CRM) Department processes.

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) business 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 form found on the company website at: 508C Tenncare Behavioral Health Adverse Occurrence Report (bcbst.com)

Examples of reportable adverse occurrences include, but are not limited to the following:

- Suicide death
- Non-suicide death that occurs in a residential, inpatient, crisis stabilization unit (CSU) or Supported Housing 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)
- Accidental injury with significant medical intervention*
- Self-injurious behavior with significant medical intervention*
- Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention*
- Treatment complications, including (medication errors and adverse medication reactions) requiring significant medical intervention*
- 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, the BCBST/BlueCare Credentialing Committee, or both.

M. Provider Network Participation

(See Section XVI. Provider Networks in this Manual for behavioral health network participation criteria.)

N. 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, and the individual should appear on the non-licensed roster (which is updated and provided to BlueCare on at least a quarterly basis in the format prescribed by BlueCare. 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 or Physician Assistant Rendering Service in Collaboration with a Physician

➢ For Behavioral Health outpatient per diem revenue codes, the required documentation should demonstrate 2-3 hours of direct service to the member (IOP, CTT, CCFT, Psych Rehab)

- 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.

O. Contact Us

Providers can locate information, tools and resources on our company websites, http://bluecare.bcbst.com and 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	CHOICES	1-800-782-2433
TennCare*Select*	1-800-711-4104	*Select*Community	1-800-292-8196

To request authorization for services, call BlueCare Tennessee Utilization Management.

BlueCare	1-888-423-0131	CoverKids	1-800-924-7141
TennCare*Select*	1-800-711-4104	BlueCare Plus	1-866-789-6314

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).

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/BCT") Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in our Provider Networks or needing to communicate any changes in their practice should review the contact list located at https://provider.bcbst.com/contact-us/my-contact and contact their local provider representative. (See Section I. Introduction, in this Manual for specific contact numbers.) For all other changes see below.

Providers may initiate a request for a copy of their own contract in Docusign and/or Availity Document viewer or initiate a request for a copy of their contract by calling our Provider Service line, 1-800-924-7141. Say "Contracts" when prompted.

By affiliating with a contracted, in-network group, individual practitioners are required to enroll in and maintain participation in every network in which that group participates, except where participation in one or more of the contracted group's networks would be prohibited by law for such individual practitioners.

If you or your patients may submit a claim to us but you aren't currently interested in network participation, and you are not affiliated with any contracted, in-network group, we recommend registering with us by completing an Out of Network Provider Form in Availity in the BlueCross Payer Space. The purpose of registering with us is to identify key information about you and ensure accurate distribution of payments, remittance advices (Explanation of Payments), and 1099 forms. This registration does not constitute or imply participation in any of our networks.

A. Application Process and Changes in Practice

Submission of an application does not constitute or guarantee participation in any BCBST network. Approval for network participation is contingent upon satisfying all requirements set forth in this section, including, but not limited to, the Network Participation Criteria detailed below. Network availability may be limited or restricted depending on participation needs.

Getting Started

There are a few requirements and steps you must take before you can begin the Enrollment Process.

Note: To alter an existing contract, please contact your network manager before submitting an application.

Facility and Ancillary Organizational Providers:

- Must have an NPI registered through NPPES at https://nppes.cms.hhs.gov/login
- Set up electronic fund transfer (EFT), as well as electronic claims and remittance, through Payer Enrollment Services at https://payerenrollservices.com/
- Must have an account with Availity®. To register, access https://provider.bcbst.com, select Log in to Availity and Create an account.

Practitioners (Medical, Dental and Behavioral Health):

Must have all of the above requirements and:

- Must register with the Council for Affordable Quality Healthcare, Inc. (CAQH) at CAQH ProView to get an ID number, give us access to your data and attest that it's correct no more than 90 calendar days prior to giving us access.

Application Process – Practitioners

If you're an individual practitioner joining a group practice that's already contracted with us, you must be eligible to participate in all the networks in which the group is contracted.

CAQH Provider ID

BlueCross BlueShield of Tennessee partners with CAQH Solutions, which offers providers a single point of entry for information. By applying for network participation via this request, you agree to be included in our roster with CAQH.

You'll need a valid and current CAQH profile. Next, you'll enroll for Electronic Funds Transfer (EFT) with Payer Enrollment Services https://payerenrollservices.com/. If your group practice participates in our BlueCare and TennCareSelect networks, you'll also need a Medicaid ID from TennCare before applying with us.

Having all of these items complete at the time you submit your online application through Availity ensures we have what we need to process your enrollment timely and smoothly, and allows you to fill out only one application with us for all networks in which your group participates.

The provider submits a Group Enrollment and/or Practitioner Enrollment Form (GEF/PEF) through Availity to start the Enrollment Process.

Existing CAQH Providers

If you have already registered and have an active CAQH Provider ID, verify that:

- Information is current and matches the information submitted on enrollment request.
- Have completed a CAQH ProView online application; and
    - All supporting documents are current and attached to your CAQH profile.
    - Attest that it's correct no more than 90 calendar days prior to giving us access.
    - Must have "authorized" BlueCross BlueShield of Tennessee (BCBST) to access your credentialing information. (If you selected "global authorization," then BCBST already has access to your data.)
    - If BCBST has not been authorized to access your credentialing information, you can complete your authorization by using the four easy steps below:

To allow BlueCross BlueShield of Tennessee access to your data:

- Go to https://proview.caqh.org and enter your username and password.
- Select the Authorize tab.
- Scroll down and select BlueCross BlueShield of Tennessee or you may select "Release my data to ANY organization that requests access".
- Accept the disclosure and select "Save" to submit your changes.

If you have questions about the CAQH Provider ID, you can contact:

- CAQH Helpdesk: 1-888-599-1771
- CAQH Email: providerhelp@proview.caqh.org
- Website: https://proview.caqh.org

BlueCross Enrollment Process

Our goal is to complete these steps in the enrollment process within 45 business days.

To check a Group Enrollment Form and/or Individual Enrollment Form visit the payor space on Availity: For instructions on using this tool see: Provider Updates and Changes Application.

This tool only allows the user to track Group Enrollment Form and/or Individual Enrollment Form progress. Direct questions to: Contracts_Reqs_GM@bcbst.com.

1. INTAKE AUDIT

Our teams confirm that we've received all your information and will contact you for additional documentation if needed.

- We may send a notification asking for additional information needed to complete the review of your application.
  Please Note: These communications require a response. Failure to respond within 30 calendar days will cause your application to be delayed or discontinued.
- You will receive a notice of discontinuation if we aren't able to process your request.

2. CREDENTIALING

- We verify all information (see Credentialing section) received from providers applying to be in network with BlueCross. We may send a letter asking for additional credentialing criteria we need to complete your application.
- We'll send a credentialing acceptance letter when our reviews are complete.
  Please Note: the date listed is the credentialing approval date, not your network participation date, which you'll receive during Provider Enrollment.
- If we're unable to credential a provider, we'll send a credentialing denied letter.

3. CONTRACTING

At this step, we approve or deny requests for participation in various BlueCross networks and send out the appropriate contracts, as applicable.

- We'll send a denial notice if the network applied for isn't available to the provider.
  Please Note: Approved contracts, amendments and other related communications will be sent through DocuSign or emailed from us.

4. ENROLLMENT AUDIT

Our teams review documentation to make sure all enrollment requirements are met, that you're credentialed or pre-approved, and that contracts are completed.

5. PROVIDER ENROLLMENT

We add the approved networks to your records and configure your information in our systems to make sure claims are paid correctly and that all information is displayed correctly in our directory.

- We'll send applicable acceptance letters with effective dates for all contracted networks.

6. ECOMMERCE

Our team will set up your EFT, electronic remittance advice, and electronic claims submission.

- You'll receive a notification confirming that the provider has been approved to transmit claims through our vendor.
- We'll send another notification letting you know that EFT is set up, and payments will be made electronically through the account you set up with Payer Enrollment Services at https://payerenrollservices.com/

Application Process for Facility and/or Ancillary Medical and Behavioral Health Providers

Facility and/or Ancillary organizations interested in participating in our networks should review the contact list located at Find My BlueCross Contact and contact their local provider representative. (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide, for specific contact numbers.)

If network participation is approved, Provider Networks & Contracting (PNC) will send an **Organizational Application** to provider within two business days.

Participation in BCBST/BCT facility and ancillary provider networks requires satisfaction of applicable network participation and credentialing requirements (see Credentialing section). Network availability may be limited or restricted depending on participation needs.

Changes in Practice

Certain federal and state regulations may require our contracted providers to timely notify us of any changes to their street address, telephone number(s), office hours, and any other changes that impact availability.

If you've moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice, please refer to the following:

- Updates for individual practitioner profiles on the Council for Affordable Quality Healthcare (CAQH) website at CAQH® ProView Profile. Updates to information not collected at CAQH® for practitioners, that are more specific to BCBST/BCT, can be submitted through the online Change Request application within the BCBST Payer Space in Availity at this link: Network Verification Form ;
- Updates for group, facility, and ancillary providers are through the online Change Request application within the BCBST Payer Space in Availity at this link: Provider Change Form .
- Questions regarding changes to provider profile can be sent to us at Contracts_Reqs@bcbst.com;

- 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 your practice.

We require individual practitioners to update and/or attest to their information in CAQH within 90 days of the notification to validate their data information. For facilities and ancillary providers, we require the return of every data verification form (DVF) received (even if there are no updates) every quarter. Depending on specialty and practice location, some providers may receive multiple attestation requests; providers must attest to each request for verification they receive. If an attestation isn't made in CAQH within a timely manner or if a DVF isn't signed, dated, and returned every quarter, the provider may be removed from our provider directory until they update and/or attest that their information is accurate. Removal from the directory won't impact network participation or claim processing. Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure provider directories used by members contain the most current and correct information about your practice.

The following changes 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.

Changes to Practitioner

Practitioners must timely report to us within 30 days prior to any changes in their practice, including but not limited to:

- Change in practice location
- A particular practitioner entering 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, State Children's Health Insurance Program, etc.) or peer review committee
- Malpractice claim(s) and/or judgment(s)
- Indictment, arrest, conviction or moral turpitude allegation
- Adversarial relationship with BCBST/BCT; and
- Any material changes, which affect the practitioner's ability to perform its obligations to members and/or BCBST/BCT
- Any material changes to the information submitted to CAQH or on our application for network participation.

These types of changes require a new PEF/GEF application and must be reported to us within 30 days prior to

- Change in practice specialty
- A particular practitioner entering an existing contracted group practice
- Change in tax or group NPI

Changes to Institutional, Ancillary Providers or Group Practices

Institutions, Ancillary Providers, and group practices must report to us within 30 days prior to any changes to their practice via the Provider Change Form located under Provider Change Form, including but not limited to:

- Provider Name
- Provider Type
- Address (Physical, Remit, Corporate or Mailing)
- Telephone or Fax Number
- Tax Identification Number
- Corporate Contact
- State License Number
- Contract Type
- Specialty
- Email Address
- 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
- Adversarial relationship with BCBST/BCT
- Any material change which affects the organization's ability to perform its obligations to member(s) and/or BCBST/BCT; and
- Any material changes in the information submitted on our application for network participation.

In the event of a Change of Ownership or Control (CHOW), including a change to or addition of a tax identification number or NPI, providers are required to adhere to the CHOW policy (see section XXVII. Attachment III of this Provider Manual) and submit a Change of Ownership or Control Notification Form.

We reserve the right to interpret and apply these criteria in our sole discretion and judgment. Any provider adversely affected by our application of these criteria will be entitled to the appropriate appeals process set forth in the Provider Dispute Resolution Procedure section of this Provider Manual.

B. Network Participation Criteria

We've established Network Participation Criteria that details the terms and conditions for participation in our provider networks. These terms and conditions will be consistently applied to all Providers regardless of participation status.

Our network participation criteria is governed by the Provider Participation Status Committee (PPSC), which evaluates and oversees Provider participation and takes appropriate actions that aren't quality of care issues. Quality of Care issues are governed by the Clinical Risk Management Committee and the Credentialing Committee.

Network participation criteria apply to any Provider who:

- Is a network provider; as defined in the applicable provider network participation agreement with us;
- Is recruited by us;
- Requests participation or re-applies for participation;
- Re-applies following voluntary or involuntary termination of the provider's participation;
- Has a significant change in practice; or
- Has another intervening event or activity, which initiates a re-application and/or reconsideration of the provider's current participation status.

Note: Specific specialty participation requirements for practitioners, institutions and ancillary providers can be found within the Credentialing section of this Provider Manual, and are in addition to and supplement, where applicable, these network participation criteria.

The following are our minimum network participation criteria:

Member Access Standards

- Agrees to provide care to members within BCBST/BCT standards for all networks.
- Demonstrates a practice history, which BCBST/BCT deems consistent and comparable with the provider's ability to comply with these standards.
- Seven-day; 24 hour coverage through participating providers required.
- Medical appointment wait time standards: refer to Member Access to Care section.

Credentialing: Ability to pass all credentialing requirements – refer to Credentialing section details.

- Must have a state medical license that's current, valid and unrestricted.

  a. If the provider's medical license is revoked, suspended or not renewed by any jurisdiction for cause or if the provider voluntarily gives up their license to avoid revocation – they may be considered for participation, at a minimum of one year after the date that the provider's license was re-instated.

b. If a revocation is still pending, or has just started, the provider won't be considered for participation unless the charges are dismissed or resolved and the license remains valid.

- Malpractice insurance – BlueCross requires malpractice coverage in the amounts of not less than 1$,000,000 per occurrence and $3,000,000 aggregate
- Successfully pass site evaluation for PCP and OB/GYN
- Not revoked from a BCBST approved Advocacy program

Quality Improvement/Utilization Review/Medical Management Program – Refer to Quality Improvement section

1. Cooperate with BCBST/BCT Quality Improvement (QI) and Utilization Management (UM) programs.
2. Maintain a QI/UM plan.
3. Demonstrate practice style and history, which we deem consistent and comparable with our quality management program standards and practices.
4. Meet our acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.

General Provisions:

1. Provider must have a physical practice location or be employed by a group practice that has a physical practice location in Tennessee or Catoosa, Dade, or Walker counties in Georgia.
2. Signed contract for network participation; network participation is dependent on the business needs of BCBST/BCT and its affiliates.
3. Meet member satisfaction standards – based on member complaints, grievances, and satisfaction survey(s).
4. Demonstrate willingness to cooperate with other providers, hospitals, and health care facilities.
5. Admitting privileges or an appropriate arrangement as defined by Credentialing with a BlueCross Network Hospital – exception must be approved by the Credentialing Committee.
6. Must have network specific 24-hour coverage.
7. Agree to participate in exclusive arrangement that's required or negotiated.
8. Satisfactory record on fraud and abuse and billing practices.
9. Must have a valid NPI.
10. Enrolled in Original Medicare (if participating in Medicare Advantage networks and required by CMS)
11. Practice style consistent with current standards of medical delivery.
12. Prescribing pattern consistent with our quality management program.
13. Abide by the terms of our Provider Dispute Resolution Procedure.
14. Must be actively engaged in our networks at our discretion (Actively engaged means personally rendering services to our members)
15. If a provider has established an adversarial relationship with us, 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 our agreements with that provider, other providers, members or other parties, the provider may not be considered for initial or continued participation in our networks.
    Such adversarial relationships may include, but aren't limited to:
    - Credible evidence of making defamatory statements about BCBST/BCT;
    - Initiating legal or administrative actions against BCBST/BCT in bad faith; Our prior or pending termination of the provider's participation agreement for cause; and
    - Prior or pending collection actions against members in violation of an applicable hold harmless requirement.
        - This participation criteria isn't 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 BCBST/BCT prior to receiving a final determination of that dispute in accordance with our Provider Dispute Resolution Procedures may be deemed, however, to constitute an adversarial relationship with us.
16. Provider's network participation agreement hasn't been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations include failure to

complete the credentialing/recredentialing process or failure to maintain hospital privileges at a network hospital, or no claims activity in the previous 12 months. For administrative terminations, the provider may reapply when the deficiency is resolved.

17. Provider or its owner/board member or managing partner has not:
    - Been indicted;
    - Been convicted of a crime;
    - Committed fraud; or
    - Been accused or convicted of any offense involving moral turpitude in any jurisdiction.
    - Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), of CMS Preclusion List.
18. Contract Terms:
    - Notice of Termination by August 1
    - Provider must maintain compliance with BCBST Contract Address requirements (refer to BCBST Contract Quick Reference Guide).
    - Accept Electronic Funds Transfer (ETF) for all payments
    - Electronic Claims Submissions required

Additional criteria for Institutional Providers:

19. Medicare Certification Requirements - Refer to Credentialing section.
20. Accreditation Requirements - Refer to Credentialing section.
21. Hospitals contracted in counties contiguous to our exclusive service area, must meet the minimum criteria to justify BlueCare and TennCare*Select* network participation. Minimum criteria include but isn't limited to satisfaction of minimum claim volumes and membership thresholds as well as market impact analysis.

C. Removal of Providers from BCBST/BCT Provider Networks

The Provider Participation Status Committee (PPSC) will review and take action on requests for removal of providers from our 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 been arrested or indicted, been convicted of a crime, committed fraud or been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons for immediate termination set forth in the Provider's Agreement. If PPSC determines a provider falls within any of these termination reasons, a provider may be immediately terminated from our networks or we may refuse participation in any of our networks.

The PPSC may also address any breach of contracts that can lead to terminating a network provider.

Providers who do not meet the required criteria may be immediately terminated from network participation or denied participation. Unless otherwise specified in the termination notice, and except as otherwise provided by applicable law, such providers may not be reconsidered for network participation, at our discretion, for a minimum of two years from the date the failed requirement is resolved. In cases involving an arrest or indictment, a provider's initial or continued participation may be denied or considered, at our discretion, unless the charges are dismissed or otherwise resolved in the provider's favor. Providers denied participation in a BlueCross network for reason other than network need may not reapply for participation for a least one year from the date of denial. Providers will be notified of the reason for denial and the applicable timeframe for reapplication, as determined by the Provider Participation Status Committee. This requirement may be waived by BlueCross in its sole discretion.

The PPSC delegated the responsibility for initiating certain administrative terminations to the Provider Network Operations (PNO) Department. Administration terminations refer to the removal of a provider from the BlueCross provider networks due to compliance related, or procedural reason. These are immediate terminations. If the PNO staff confirms all BCBST/BCT policies and procedures were followed related to such administrative terminations, notice of termination may be sent to a provider without PPSC review. If the PNO staff identifies unique circumstances that warrant a committee level review, the termination action may be brought to the PPSC. A list of delegated terminations include, without limitation:

- Loss of License

- Loss of DEA registration, if applicable
- Lack of appropriate malpractice/general liability insurance
- Revoked from a BCBST approved Advocacy program
- Loss of credentialing
- Medicare/Medicaid or SCHIP sanctions
- Retired/deceased/moved out of our exclusive service area
- Excluded from participation in the Medicare/Medicaid and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101 or otherwise not in good standing with the Division of TennCare
- Debarred from receiving federal contract by the General Services Administration and listed on the System for Award Management (SAM) database
- Debarred or suspended by the Federal Employee Program/Postal Service Health Benefits Office of Personal Management
- No claims activity within 12 consecutive months at our discretion (no claims activity means the provider's NPI doesn't appear on any claims)
- Inclusion on CMS's Opt-Out List
- Inclusion on CMS's Preclusion List
- Lack of a valid NPI
- Deactivated NPI or no NPI
- Termination of Medicaid ID/participation by the Division of TennCare

A report will be submitted to the PPSC reflecting administrative terminations at least quarterly.

If a provider is removed from our networks, their credentials will be suspended on the effective date of the contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

D. Provider Termination Appeal Process

Providers whose network participation has been terminated pursuant to the terms of their contract may be entitled to the procedural remedies set forth below (except as set forth in Quality Improvement Program section or Provider Dispute Resolution Procedure section).

All notices concerning network participation contract terminations, whether with cause or without cause are communicated to the provider according to the provisions in the 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 our reporting obligations to regulatory agencies.

1. APPEAL: WITH CAUSE TERMINATION OF A PARTICIPATING PROVIDER

a. Reconsideration

i. The provider may request a reconsideration of our decision by submitting a request in writing within 30 days of the date of the notice of termination. Failure to meet this requirement will result in a waiver of the right to appeal the termination. The PPSC will send a response to the provider after receiving a request for reconsideration.

b. Appeal

i. If a provider isn't satisfied with our response to their reconsideration request, they may request an appeal by telephonic hearing. Provider must request in writing a telephonic hearing no later than 14 days after receiving our decision on their 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), we'll contact them to establish a mutually acceptable date and time for the telephonic hearing, which generally will be conducted within the 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/BCT.
iv. For institutional and ancillary providers, telephonic hearings shall be conducted by a hearing officer chosen by BCBST/BCT.
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:

a. 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.
b. The hearing may be recorded by a court reporter at our discretion.
c. The provider and BCBST/BCT 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 working days) before the date of the hearing.
d. 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.
e. During the hearing, each party has the right to:
   i. Call witnesses
   ii. Cross-examine opposing witnesses
f. 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/BCT and the provider a written response within 60 days of the date of the telephonic hearing. The decision will be reviewed by the PPSC and our final decision will be sent to the provider.

c. Binding Arbitration

i. If the provider isn't satisfied with our 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: DENIAL OF APPLICATION

a. Written Appeal

i. A provider may appeal by submitting a written statement of their position within 30 days of receipt of the notice of the application denial. The written appeal will be reviewed by the PPSC. A written response will be sent to the provider within 60 days of our receipt of the written appeal.

b. Binding Arbitration

i. If the provider isn't 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).

E. Federal Exclusion Screening Requirements

The following definitions apply for the purpose of the Exclusion Screening Requirements:

- Exclusion Lists
  - 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), the Social Security Death Master File (DMF) and TennCare's Terminated Providers List.
- Ineligible Persons
  - Any individual or entity who:

- Is excluded, debarred, suspended or otherwise ineligible to participate in federal healthcare programs or in federal procurement or non-procurement programs (as of the date such Exclusion Lists are accessed by the provider); or
- Has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320(a)-7(a), but hasn't been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their obligation to screen all employees, agents and contractors (Exclusion Screening Process) against the Exclusion Lists. They also need to conduct criminal background checks and registry checks and exclusion checks, excluding checks against the Social Security Master Death File, in accordance with state law to determine whether any employee, agents, and contractors have been determined to be Ineligible Persons (making them, excluded from participation in the Medicare or Medicaid programs). At minimum, registry and exclusion checks must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and TennCare's Terminated Provider List. The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and monthly thereafter. Providers are also required to have employees and contractors disclose whether they're Ineligible Persons prior to providing any services on behalf of the provider. The Exclusion Screening Process is a Centers for Medicare and Medicaid Services (CMS) requirement and a condition of the provider's enrollment as a BCBST/BCT provider and is also a continuing obligation during their contractual term.

Providers and their subcontractors must comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screening. Provider entities that bill and/or receive federal funds agreement must screen their owners, board member, agents, and employees against the Exclusion Lists on a monthly basis. In addition, the provider and subcontractors shall screen their owner and employees against the Social Security Master Death File at least on an annual basis. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits must be refunded to and/or recouped by the BCBST/BCT.

BCBST/BCT Providers must immediately report any exclusion information discovered. (See Introduction section for a listing of appropriate contact numbers.)

If a provider determines that an owner, board member, employee or contractor is an Ineligible Person, they'll need to take the appropriate action to remove the owner, board member, employee or contractor from responsibility for, or involvement with the provider's operations related to federal healthcare programs. In such event, the provider must take all appropriate actions to ensure that the responsibilities of such owner, board member, employee or contractor haven't and won't adversely affect the quality of care rendered to any BCBST/BCT member of any federal health care program.

EXCLUDED PROVIDER

If we discover that a provider has been excluded, precluded, or debarred, we'll remove that provider from all our Medicare, Medicaid participating networks in accordance with the administrative termination provisions in Section D. We'll also recover any claims reimbursed after the exclusion effective date.

EXCLUDED PRACTITIONER IN A GROUP

If we discover a practitioner who is the owner of a group practice is excluded, precluded, or debarred, we'll remove the group from all Medicare and Medicaid participating networks in accordance with the administrative termination provisions in Section D. We'll also recover any claims reimbursed after the exclusion effective date.

If we discover a practitioner that is part of a group practice is excluded, precluded, or debarred, we'll remove that practitioner from all our participating networks in accordance with the administrative termination provisions in Section D. We'll also recover any claims reimbursed for dates of service after the exclusion effective date.

A provider may present documentation to support that the practitioner wasn't hired or affiliated with them on or after the exclusion effective date for us to adjust the claims recovery period. In addition to the supporting documentation, an attestation must be obtained from BCBST/BCT to indicate the dates that practitioner was employed by or associated with the provider. The supporting documentation and attestation must be received within 30 days of the date of the termination notice.

EXCLUDED OWNER, BOARD MEMBER, OR EMPLOYEE

If we discover that an owner, board member, or employee of the provider has been excluded, we'll remove the provider from all Medicare and Medicaid participating networks in accordance with the administrative termination provisions in Section D. We'll also recover any claims reimbursed after the exclusion effective date.

A provider may present documentation to support that the owner, board member, or employee wasn't hired or affiliated with them on or after the exclusion effective for us to adjust the claims recovery period. In addition to the supporting documentation, an attestation must be obtained from BCBST/BCT to indicate the dates that the owner, board member, employee or contractor was employed by or associated with the provider. The supporting documentation and attestation must be received within 30 days of the date of the termination notice. The claims recovery period won't be adjusted until the provider updates the ownership information in the TennCare Provider Registration Portal to reflect the information in the supporting documentation and attestation.

RECOUPMENT OF CLAIMS PAID TO OR FOR THE BENEFIT OF EXCLUDED PROVIDERS

If a provider or group is removed from our participating networks under this section as an excluded provider, we'll reprocess claims for all dates of service after the exclusion effective date. Some plans or products prohibit payment to excluded providers; BlueCross will recover any payments for these plans or products previously made to or for the benefit of an excluded provider during the exclusion period.

If the excluded provider is the owner of a group, claims for the group are not eligible for payment, and BlueCross will recover any payments for these plans or products previously made to the group during the exclusion period.

F. Subcontracting

Prior Approval

Providers who participate in the BlueCare and TennCare*Select* networks may not subcontract any part of covered services without written agreement from BlueCare Tennessee. Without prior approval, claims for services provided by the subcontractor could be denied and previous payments could be subject to recoupment.

Please refer to the Subcontracting section of your BlueCare Provider Agreement.

To request approval for all provider subcontracts, providers in our networks must submit the BlueCare Tennessee Provider Subcontracting Form and Attestation. Providers must also complete the Exhibit for Subcontractors Compliance with Terms of BlueCare Tennessee Provider Agreement. You can find both document in the Administrative Information>Office Administration section our Provider Forms page.

BlueCare Providers will submit these requests to TennCare_Provider_Subcontracts@bcbst.com

Fraud, Waste and Abuse Training

In addition, Deficit Reduction Act/Fraud Waste and Abuse training shall be provided to the employees of subcontractors supporting the BlueCare Tennessee contract. The date the training was provided as well as the attendees should be documented.

Required Screening

BlueCare Tennessee Providers must also require that their subcontractor screen all employees prior to hiring and every month after hiring against the federal exclusion OIG List of Excluded Individuals and Entities (LEIE), TennCare's Terminated Provider List, and the System for Award Management (SAM) databases. The results of the screenings should be documented. In addition, subcontractors must verify that employees aren't listed on the Tennessee Abuse Registry, Tennessee Felony Offender Registry, and the National and Tennessee Sexual Offender Registries either pre-hire or prior to the subcontractor entering into an agreement with a BlueCare provider.

Records Retention

Records related to all subcontract agreements should be maintained for a minimum of ten (10) years after your agreement with BlueCare Tennessee expires and/or follow the language outlined in contract.

Termination of Services

In the event a provider is terminating a contract with a BlueCare approved subcontractor, please complete the BlueCare Tennessee Provider Subcontracting Termination Form also located in the Administrative Information>Office Administration section of our Provider Forms page.

Our BlueCare network providers should send completed forms to:
TennCare_Provider_Subcontracts@bcbst.com

G. Professional Provider Contracting – Practice Type

BlueCare Tennessee Provider Network Participation Agreements effective, or amended, on or after Nov. 1, 2025, may include reference to "Practice Type" in the heading of the professional services Network Attachment. BlueCare uses the Practice Type designation, as defined below, to indicate the professional practitioners to whom the rates in that Network Attachment apply. BlueCare may add other Practice Types in the future; any such additions will be included in this section.

BlueCare defines the following Practice Type(s) for use in Network Attachments with effective dates on or after Nov. 1, 2025:

- **Medical**

  Medical practitioners are all professional practitioners contracted and credentialed with BlueCare EXCEPT those defined below as Behavioral Health.

- **Medical and Behavioral Health**

  Medical and Behavioral Health practitioners are all professional practitioners contracted and credentialed with BlueCare.

- **Behavioral Health**

  Behavioral Health practitioners are independently licensed professionals who deliver clinical services for the prevention, diagnosis, and treatment of mental health conditions, emotional disorders, and substance use disorders. These services may include assessment, psychotherapy, counseling, medication management and other evidence-based interventions aimed at improving behavioral emotional, and psychological well-being. This Practice Type includes only the following BlueCare contracted and credentialed specialties:

  - Psychiatry & Neurology, Addiction Medicine
  - Psychiatry & Neurology, Addiction Psychiatry
  - Psychiatry & Neurology, Behavioral Neurology & Neuropsychiatry
  - Psychiatry & Neurology, Child & Adolescent Psychiatry
  - Psychiatry & Neurology, Forensic Psychiatry
  - Psychiatry & Neurology, Geriatric Psychiatry
  - Psychiatry & Neurology, Neurodevelopmental Disabilities
  - Psychiatry & Neurology, Psychiatry
  - Psychiatry & Neurology, Psychosomatic Medicine
  - Psychologist, Clinical
  - Psychologist, Clinical Child & Adolescent
  - Nurse Practitioner, Psych/Mental Health
  - Counselor, Professional
  - Marriage & Family Therapist
  - Social Worker, Clinical

Behavioral Health Practitioner specialty titles may vary; however, they are generally classified under one of the Behavioral Health Practitioner specialties listed above. It is the responsibility of each provider to review the Credentialing section of this manual for additional information regarding specialty definitions, credentialing requirements, and any applicable guidelines.

Examples of practitioner specialty categories excluded from the Provider Type for Behavioral Health are Primary Care Practitioners, Medical Specialist Practitioners, Behavior Analysts, Dental Providers, or any other non-behavioral health disciplines.

Note: Licensed Board Certified Behavior Analysts (BCBAs), are excluded from the Behavioral Health Practice Type. Services performed by BCBAs are contracted separately under a distinct Network Attachment.

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XVII. Credentialing

A. Introduction

The BlueCross BlueShield of Tennessee/BlueCare Tennessee Credentialing Program was established Aug. 1, 1995. The Credentialing Program is designed around goals that reflect the BlueCross/BlueCare mission, as well as regulatory and accrediting requirements.

To ensure consistent standards for network participation and compliance with regulatory requirements, we have established a **network participation process that includes our Credentialing program**.

- **Individual practitioners** seeking network participation must complete an application through the **Council for Affordable Quality Healthcare (CAQH).** CAQH Solutions provides a centralized platform that streamlines the submission of provider information.
- In addition, all providers are required to submit a **Provider Enrollment Form** via **Availity**.
- **Organizational Providers** are required to submit a completed Organization application provided by BlueCross BlueShield of Tennessee.

Using the submitted CAQH or facility application, we conduct a **preliminary evaluation** to determine eligibility for network participation. All applicants must:

- Complete the application in full
- Submit all required documentation
- Successfully complete the credentialing process

Credentialing must be finalized before network participation can begin. For information on the network participation process, please see the Provider Networks section of this Manual.

Verifying credentials of practitioners and organizational providers is an essential component of an integrated health care system. The credentialing process includes a continuous evaluation of the quality of care provided by individual practitioners and organizational providers seeking participation in our 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 may, in its discretion, make case-by-case decisions regarding the credentialing or continued credentialing of practitioners or organizations that meet exception criteria. While some may be approved under these criteria, others may be denied or have their credentials terminated, based on the Committee's evaluation. Each case is individually assessed to determine whether credentialing aligns with the best interests of BlueCross BlueShield of Tennessee and its members. The Committee may also choose to deny credentialing to practitioners or organizations within a specific exception category if it determines that doing so is necessary to protect the health and welfare of our members.

Practitioners and organizational providers have the right to:

- **Review** information submitted with their credentialing or recredentialing application, excluding peer-review protected materials.
- **Request** corrections to any erroneous information within **30 calendar days** of receipt of the completed application. Requests should be submitted via the contact methods listed below.
- **Inquire about the status** of their credentialing or recredentialing application at any time.

For questions or concerns regarding the credentialing process or specific applications, please contact:

BlueCross BlueShield of Tennessee – Credentialing Department

Toll-Free Phone: 1-800-924-7141

Fax: 1-423-535-8357
Alternate Fax: 1-423-535-6711
Email: Credentials@bcbst.com

Note: For information regarding denial or appeal rights, please refer to the **Medical Management Corrective Action** Plan in **Section XI. (D)** of the **Quality Improvement Program** section of this Manual.

B. Credentialing Application

Credentialing applications are used to consistently collect key information from all practitioners and organizational seeking to join our networks.

Our credentialing standards apply to all **licensed independent practitioners** and **organizational providers** who maintain a direct contractual relationship with us.

The **Credentialing Program** evaluates whether these individual practitioners and organizational providers licensed by the state and contracted with us and are qualified to deliver services and meet the minimum standards set by:

- The **National Committee for Quality Assurance (NCQA)**
- The **Centers for Medicare & Medicaid Services (CMS)**
- The **TennCare Contractor Risk Agreement**

Verifying all required credentials is a critical part of this process to ensure quality and compliance.

> Once practitioners and organizational providers have completed the credentialing process, they'll receive written notification **within 10 days** from our Credentialing Department.
>
> **Note**: This notification doesn't guarantee acceptance in our networks; practitioners and organizational providers are not considered participating in our networks **until they receive an acceptance letter** from our Contracting Department.

C. Credentialing Policies

Please note that credentialing policies are subject to change. Final decisions regarding credentialing status are made by the **Credentialing Committee.**

For questions regarding credentialing or if assistance is needed, providers may contact their **Provider Representative** by visiting our Contact Us page at https://provider.bcbst.com/contact-us/my-contact.

Alternatively, Customer Service may be reached directly at 1-800-924-7141.

1. Credentialing Process for Practitioner: (Medical and Behavioral Health)

BlueCross obtains practitioner data for the credentialing process from **CAQH**. Practitioners are required to complete their CAQH profile fully and accurately and must attest to the information within **120 calendar days** prior to submitting their application for participation in a BlueCross network.

Additionally, practitioners must submit an **online enrollment form through Availity** to request, add, or update a specialty. For more details, refer to the section title **Provider Networks.**

As part of this credentialing process, BlueCross will verify all required information based on the data attested to in the CAQH application. Any exceptions to the standard or additional criteria will be reviewed and determined by the **Committee.**

Base practitioner credentialing criteria (section references are to the CAQH application):

Section 1, Personal Information and Professional IDs

- **Personal Email Contact.** Ensure the personal email contact is correct (we use this contact only if there is no response using the Section 3 contact)
- **Drug Enforcement Administration (DEA).** BlueCross requires a current, valid, and unrestricted DEA with all schedules

- **License.** BlueCross requires a current, valid, full, and unrestricted license to practice as a healthcare professional in the state(s) where services will be rendered.

Section 2, Education and Training

- **Education and training.** BlueCross will use the provided education and training to determine specialty eligibility.

Section 3, Professional/Medical Specialty Information

- **Board Certification**, if applicable. BlueCross will use the provided board certification information to determine specialty eligibility.
- **Certification.** Certifications for nurse practitioners and physician assistants should be listed in this section. BlueCross requires submission of a copy of the ANCC or AANP certification.
- **Primary Credentialing Contact.** BlueCross will use this contact for all credentialing correspondence, regardless of what is submitted on the enrollment form.

Section 4, Practice Location Information

- **Current practice location.** BlueCross will use this information to determine where the practitioner is currently practicing.
- **Call Coverage.** BlueCross requires 24-hour, seven-day-a-week call coverage or arrangements with a BlueCross credentialed or contracted practitioner or hospitalist group. Please note this is indicated on the CAQH application as “Covering Colleagues”.

Section 5, Hospital Affiliations

- **Hospital Privileges.** BlueCross requires unrestricted hospital privileges.
- **Admitting arrangements.** The Credentialing Committee will determine if an admitting arrangement will be allowed. If allowed, the admitting arrangement must be with a BlueCross credentialed practitioner or hospitalist group.

Section 6, Professional Liability Insurance Carrier

- **Certificate of Insurance.** BlueCross requires malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (exceptions made for state employees).

Section 7, Work History and References

- **Work History.** BlueCross requires work history for the last five years with documented gaps in employment over six months.

Section 8, Disclosure Questions

- **Disclosure questions.** BlueCross requires an answer to all 26 disclosure questions. A detailed explanation of any question(s) answered “Yes” on the application will be required.

Some practitioner specialties may require specific licenses, certifications, or education. Others might be exempt from certain base requirements. These differences are listed below. If a specialty isn’t listed, the general base requirements above apply.

Acupuncturist:

- **Licensed as an Acupuncturist**
- Certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- DEA certificate isn’t required
- Call coverage isn’t required
- Hospital privileges aren’t required

Audiologist:

- **Licensed as an Audiologist**
- DEA certificate isn’t required
- Call coverage isn’t required
- Hospital privileges aren’t required

Behavior Analyst (CBA):

- **Licensed in the state of Tennessee as a Behavior Analyst**
- Practitioner must be a board certified Behavior Analyst-Doctoral (BCBA D) by the Behavior Analyst Certification Board (BACB)
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Certified Anesthesiologist Assistant (CAA or AA):

- Licensed as an Anesthesiologist Assistant in Tennessee
- DEA Certificate isn't required
- Hospital privileges aren't required

Certified Registered Nurse Anesthetist (CRNA):

- Licensed as a Registered Nurse and an Advance Practice Nurse with qualifications listed as Nurse Anesthetist
- DEA Certificate isn't required
- Hospital privileges aren't required

Chiropractor:

- **Licensed as a Chiropractor**
- Hospital privileges aren't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required

Chiropractors performing Acupuncture:

- If the state license has acupuncture listed at the bottom, the practitioner has met the state's educational requirements to perform acupuncture

Dentist – Dental Anesthesiology:

- **Licensed as a Dentist (DDS or DMD)**
- Completion of residency in Dental Anesthesia or Board certification from the American Dental Board of Anesthesiology (ADBA)

Dentist – Endodontics; Periodontist; Prosthodontics:

- **Licensed as a Dentist**
- Hospital privileges aren't required

Dentist (General):

- **Licensed as a Dentist**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist - Oral & Maxillofacial Surgeon (DDS, or DMD):

- **Licensed as a Dentist (DDS or DMD):**
- Completion of residency in Oral and Maxillofacial Surgery or ABOMS board certification

Dentist - Orthodontics:

- **Licensed as a Dentist – must list specialty of Orthodontics and Dentofacial Orthopedics**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist – Pediatric:

- **Licensed as a Dentist**
- Completion of Pediatric Dentist residency or license must list specialty of Pediatric Dentist
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dermatology:

- **Licensed as a MD or DO with specialty of Dermatology**
- Hospital privileges are required for Micrographic Surgery (MOHS). If practitioner doesn't have their own privileges, an admitting arrangement or hospital group is acceptable

Dietitian/Nutritionist:

- **Licensed as a Dietitian/Nutritionist.**
- Accreditation from the Commission on Dietetic Registration (CDR)
- Call coverage isn't required
- DEA certificate isn't re required
- Hospital privileges aren't required

Genetic Counselors:

- State licensed or certified at the highest level of independent practice in the state where practice is to occur
- Hospital privileges aren't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required

Hospice & Palliative Care Practitioner:

- **Licensed as a MD or DO**
- Hospital privileges aren't required

Lactation Specialist:

- **Licensed as a BCBST recognized specialty**
- Certification with IBCLC: Global Certification for Lactation Consultant required
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Licensed Clinical Social Worker (LCSW):

- **Licensed as a Clinical Social Worker**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Marriage and Family Therapist:

- **Licensed as a Marriage and Family Therapist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Nurse Practitioner or Nurse Mid-Wife:

- **Registered Nurse (RN) License**
- **Advanced Practice Nurse (APN) certificate in Tennessee and applicable prescriptive authority for contiguous states**

- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting
- DEA certificate isn't required

Nurse Practitioner – Master's Clinical Nurse Specialist/Psychiatric Nurse:

- **RN License – May be from any state if it says multi-state**
- **Advanced Practice Nurse (APN) certificate in TN (Must have an active NP license in each state that they practice**
- Certification by American Nurses Credentialing Center as Nurse Practitioner - Psychiatric / Mental Health is required.
- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting
- DEA certificate isn't required

Occupational Therapist:

- **Licensed as an Occupational Therapist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Optometrist:

- **State license must contain Therapeutic Certification**
- Hospital privileges aren't required
- DEA certificate isn't required
- Call coverage isn't required

Pathologist:

- **Licensed as a MD or DO with the specialty listed as Pathologist**
- Hospital privileges aren't required
- DEA certificate isn't required
- Call coverage isn't required

Pharmacist – Clinical, Immunizing, or Disease Management:

- **Licensed as a Pharmacist**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Physical Therapist

- **Licensed as a Physical Therapist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Physician Assistant:

- **Licensed as a Physician Assistant**
- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospital group may also be listed as admitting
- DEA certificate isn't required

Physician Assistant – Surgical Assist:

- **Licensed as a Physician Assistant**
- National Commission on Certification of Physician Assistants (NCCPA) certification is required
- DEA certificate isn't required
- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting

Podiatrist:

- **Licensed as a Podiatrist**
- Hospital privileges aren't required

Podiatrist – Foot and Ankle Surgery:

- **Licensed as a Podiatrist**
- Hospital privileges are required – **Admitting arrangement with a BCBST credentialed and/or contracted provider or hospitalist group is acceptable**

Professional Counselors:

Includes: Addiction Counselors, Alcohol and Drug Counselors, Mental Health Counselors, Senior Psychological Examiner (SPE), and Employee Assistance Professional Counselor (EAP)

- **State licensed or certified at the highest level of independent practice in the state where practice occurs**
- Hospital privileges aren't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required

Psychologists - Clinical or Clinical Child & Adolescent Psychologists (includes Psychologist and Psychoanalyst):

- **Licensed as a Psychologist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Psychologists – Tele-Health Provider with a PSYPACT license:

- **Practitioner must have a PSYPACT license**
- **Practitioner must be licensed as a Psychologist in the APIT Home State listed on the PSYPACT license**
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Radiologist Diagnostic:

- **Licensed as a MD or DO with the specialty listed as Radiologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Radiology – Interventional:

- **Licensed as a MD or DO with the specialty listed as a Radiologist**
- Hospital privileges are required - **Practitioner must have his/her own privileges**

Sleep Medicine:

- **Must be licensed as a MD or DO**
- Education and/or board certification in Sleep Medicine required

Speech Language Pathologist or Speech Therapist:

- **Licensed as a Speech Language Pathologist**
- DEA certificate isn't required
- Call coverage isn't required

- Hospital privileges aren't required

Surgery, General:

- **Must be licensed as a MD or DO**
- Education and/or board certification in Surgery required
- Hospital privileges are required - **Practitioner must have his/her own admitting privileges**

2. Credentialing Process for Medical and Behavioral Health Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensuring decisions are based on the most accurate, current information available. The following types of medical and behavioral health organizational providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

Organizational providers must be recredentialed every 36 months to meet federal and state regulatory guidelines.

The following information is required and/or that must be verified for organizational providers:

- **Licensed in the State of Tennessee** – Providers receive a new license each year and it's considered proof of compliance; therefore, no site visit is required
- 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: AAAASF(QUAD A), AAAHC/URAC, AAPM, AASM, ABCOP, ACHC, AOA, CABC, CARF, CHAP, CIHQ, COA, CORF, CUC, DNV-GL, HFAP, HQAA, National Association of Boards of Pharmacy, NBAOS, SAMHSA, UCAOA / CAUCQ or The Joint Commission (TJC). If not accredited, State or Federal review in lieu of a site visit is the last 3 years
- Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
- DEA certificate, if applicable
- History of federal and/or state sanctions
- An Attestation to the correctness and completion of the application

Acute Care Facility Hospital:

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, AAAHC, CIHQ or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site review in the last 3 years

Ambulatory Infusion Center (AIC):

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, AAAHC, CIHQ or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site review in the last 3 years

Ambulatory Surgical Facility:

- **Licensed as an Ambulatory Surgery Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, AAAASF (QUAD A), or CIHQ certification required

Birthing Centers:

- **Licensed as a Birthing Center in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable

- TJC, CHAP, AAAHC, or CIHQ certification required

Community Mental Health Center:

- **Licensed as a Mental Health Outpatient Facility**

Crisis Stabilization Unit:

- **Licensed as a Crisis Stabilization Unit**
- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by, CARF or COA or accredits the program itself as an observation/holding bed program that provides psychiatric services

Dialysis Facility:

- **Licensed as End Stage Renal Diseases (ESRD) Facility License**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA certificate required

Durable Medical Equipment (DME) Providers:

- **Licensed as a DME Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- DEA certificate, if applicable
- Pharmacy License, if applicable
- TJC, CHAP, AAAHC, BOC, The Compliance Team, ABC, NBAOC, CARF, CIHQ, HQAA or ACHC required

Health Department:

- **License isn't required**
- State Tort Insurance
- CLIA Certificate

Home Infusion Therapy Providers:

- **TN: Licensed as a Pharmacy License**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- Accreditation isn't required

Home Health Agency:

- **Licensed as a Home Health Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Hospice Provider:

- **Licensed as a Hospice Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Independent Lab:

- **Licensed as a Laboratory in Tennessee – Labs located in a physician office, hospital etc. are exempt from licensure requirements**
- Other States: Licensed according to that state's licensing laws
- Must have referral from a BCBST participating/network provider
- Accreditation isn't required
- CLIA certificate is required

Inpatient Rehabilitation Facility:

- **Licensed as an Inpatient Rehabilitation Facility in Tennessee**

- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- DEA certificate, if applicable
- TJC, CARF, or CIHQ accreditation required (no exceptions)

Intensive Outpatient (Psychiatric):

- **Licensed as a Mental Health Outpatient Facility**
- DEA certificate isn't required
- Must provide services at least three (3) hours per day, at least 2 days a week

Intensive Outpatient (Substance Abuse Disorder):

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- DEA certificate isn't required
- Must provide services at least (3) three hours per day, at least two (2) days a week

Non-Licensed DME Providers (Non-motorized equipment only. e.g., walker canes, crutches):

- **License isn't required**
- DEA certificate isn't required
- Accreditation isn't required

On-Site Clinic:

- **State Business License**
- Accreditation by Urgent Care Association of Americal (UCAOA) / Commission on Ambulatory and Urgent Care Quality (CAUCQ). Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

Orthotic/Prosthetic Supplier:

- **License isn't required**
- Board of Certification/Accreditation (BOC) is required

Opioid Treatment Program:

- **TN: Licensed as an Opioid Treatment Program (OTP)**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate is required
- CLIA certification, if applicable
- Certification by a SAMHSA required
- Must be accredited by, TJC, CARF, or COA

Outpatient Diagnostic Facility:

- **Not licensed**
- CLIA certification, if applicable

Outpatient Mental Health Facility:

- **Licensed as a Mental Health Outpatient Facility**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Substance Abuse Disorder Clinic:

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Rehabilitation Facility:

- **Not Licensed**
- Accreditation isn't required
- CLIA isn't required unless they have an onsite laboratory

Pain Management Center:

- **TN: Licensed as an Ambulatory Surgical Facility**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate isn't required
- Must have CARF accreditation or American Academy of Pain Management accreditation

Partial Hospitalization (Psychiatric):

- **Licensed as a Mental Health Partial Hospitalization Facility**
- Accreditation isn't required
- DEA certificate isn't required

Partial Hospitalization (Substance Use Disorder):

- **Licensed as an Alcohol and Drug Non-Residential Rehabilitation Treatment Facility license, Mental Health Partial Hospitalization Facility, and Alcohol and Drug Outpatient Detox license**
- Accreditation isn't required
- DEA certificate isn't required

Professional Support Services Licensure:

- **TN: Licensed as a Professional Support Service**
- Member of DDA (Department of Disability and Aging)

Psychiatric Hospital:

- **TN: Licensed as a Mental Health Hospital Facility**
- Other States: licensed in accordance with the state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, CIHQ, AAAHC, or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site review in the last 3 years

Psychiatric/Residential:

- **Licensed as a Mental Health Residential Treatment Center**
- Accreditation isn't required
- DEA certificate not required

Psychosocial Rehabilitation Center:

- **Licensed as a Mental Health Psychosocial Rehabilitation Center**
- Accreditation isn't required
- DEA certification isn't required

Rural Health Clinics:

- **Not licensed**
- State Tort insurance
- CLIA certification required
- Accreditation isn't required

Skilled Nursing Facility (No Swing Beds):

- **TN: Licensed as a Nursing Home**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA isn't required
- DEA certificate isn't required
- Accreditation isn't required

Sleep Labs:

- **Not licensed**
- Accreditation by American Academy of Sleep Medicine (AASM) or TJC or CIHQ required

Substance Abuse Disorder Residential:

- **Licensed as an Alcohol and Drug Residential Treatment Center**
- DEA certificate isn't required
- Accreditation isn't required

Supportive Housing:

- **Licensed as either a Supportive Living Facility or a Supportive Residential Facility**
- **Assisted Care Living Facility (ACLF) Residential Facility, Mental Health Supportive Living Facility, or DIDD license are acceptable.**
- Accreditation isn't required
- DEA certificate isn't required

Urgent Care Centers:

- **State Business License**
- Accreditation or certification by Urgent Care Association of America (UCAOA), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

3. Recredentialing Process

All Medical or behavioral health providers will be recredentialed every 36 months.

In addition to the information that will be verified by primary or secondary sources, we'll include and consider collected information for the participating provider's performance within the health plan, including information collected through the health plan's quality management program.

Recredentialing will begin approximately three to six 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 we'll retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the Provider 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's subject to change must be re-verified from primary sources during the recredentialing process. The provider must attest to any limits on their ability to perform essential functions of the position and attest to absence of current illegal drug use.

4. Approved Specialties

We recognize and maintain 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.

Practitioners must designate a specialty on the credentialing application. To be listed in any of our 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.
    - *Fellowship training will only be recognized for those specialties where there is not a residency program for the specialty. Completion of a fellowship program in a specialty for a limited time period will not be recognized if the applicant has not completed the full residency program for that specialty. Recognition of fellowship training will be made in the sole discretion of BCBST.
- 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

II. American Board of Anesthesiology

A. Adult Cardiac Anesthesiology
B. Anesthesiology
C. Critical Care Medicine
D. Health Care Administration, Leadership, and Management
E. Hospice and Palliative Medicine
F. Neurocritical Care
G. Pain Medicine
H. Pediatric Anesthesiology
I. Sleep Medicine

III. American Board of Colon and Rectal Surgery

A. Colon and Rectal Surgery

IV. American Board of Dermatology

A. Dermatopathology
B. Micrographic Dermatologic Surgery
C. Pediatric Dermatology

V. American Board of Emergency Medicine

A. Anesthesiology Critical Care Medicine
B. Emergency Medical Services
C. Health Care Administration, Leadership, and Management
D. Hospice and Palliative Medicine
E. Internal Medicine – Critical Care Medicine
F. Medical Toxicology
G. Neurocritical Care
H. Pain Medicine
I. Pediatric Emergency Medicine
J. Sports Medicine
K. Undersea-Hyperbaric Medicine

VI. American Board of Family Medicine

A. Adolescent Medicine
B. Family Medicine
C. Geriatric Medicine
D. Health Care Administration, Leadership, and Management
E. Hospice and Palliative Medicine
F. Pain Medicine
G. Sleep Medicine
H. Sports Medicine

VII. American Board of Internal Medicine

A. Adolescent Medicine
B. Adult Congenital Heart Disease
C. Advanced Heart Failure and Transplant Cardiology
D. Cardiovascular Disease
E. Clinical Cardiac Electrophysiology
F. Critical Care Medicine
G. Endocrinology, Diabetes, and Metabolism
H. Gastroenterology
I. Geriatric Medicine
J. Hematology
K. Hospice and Palliative Medicine
L. Infectious Disease
M. Internal Medicine
N. Interventional Cardiology

O. Medical Oncology
P. Nephrology
Q. Neurocritical Care
R. Pulmonary Disease
S. Rheumatology
T. Sleep Medicine
U. Sports Medicine
V. Transplant Hepatology

VIII. American Board of Medical Genetics and Genomics, Inc.

A. Clinical Biochemical Genetics
B. Clinical Genetics and Genomics, (MD)
C. Laboratory Genetics and Genomics
D. Medical Biochemical Genetics
E. Molecular Genetic Pathology

IX. American Board of Neurological Surgery

A. Neurological Surgery
B. Neurocritical Care

X. American Board of Nuclear Medicine

A. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology

A. Complex Family Planning
B. Critical Care Medicine
C. Gynecologic Oncology
D. Gynecology
E. Maternal Fetal Medicine
F. Obstetrics
G. Obstetrics and Gynecology
H. Reproductive Endocrinology and Infertility
I. Urogynecology and Reconstructive Pelvic Surgery

XII. American Board of Ophthalmology

A. Ophthalmology

XIII. American Board of Orthopedic Surgery

A. Orthopedic Surgery
B. Orthopedic Sports Medicine
C. Surgery of the Hand

XIV. American Board of Otolaryngology

A. Complex Pediatric Otolaryngology
B. Neurotology
C. Otolaryngology – Head and Neck Surgery
D. Plastic Surgery within the head and neck
E. Sleep Medicine

XV. American Board of Pathology

A. Pathology – Anatomic/Pathology - Clinical
B. Pathology – Anatomic
C. Pathology - Clinical
D. Blood Banking Transfusion Medicine
E. Clinical Informatics
F. Cytopathology
G. Dermatopathology

H. Hematopathology
I. Neuropathology
J. Pathology – Chemical
K. Pathology – Forensic
L. Pathology – Medical Microbiology
M. Pathology – Molecular Genetic
N. Pathology – Pediatric

XVI. American Board of Pediatrics

A. Adolescent Medicine
B. Child Abuse Pediatrics
C. Developmental-Behavioral Pediatrics
D. Hospice and Palliative Medicine
E. Medical Toxicology
F. Neonatal-Perinatal Medicine
G. Pediatrics
H. Pediatric Cardiology
I. Pediatric Critical Care Medicine
J. Pediatric Emergency Medicine
K. Pediatric Endocrinology
L. Pediatric Gastroenterology
M. Pediatric Hematology-Oncology
N. Pediatric Hospital Medicine
O. Pediatric Infectious Disease
P. Pediatric Nephrology
Q. Pediatric Pulmonology
R. Pediatric Rheumatology
S. Pediatric Transplant Hepatology
T. Sleep Medicine
U. Sports Medicine

XVII. American Board of Physical Medicine and Rehabilitation

A. Brain Injury Medicine
B. Neuromuscular Medicine
C. Pain Management
D. Pediatric Rehabilitation Medicine
E. Physical Medicine and Rehabilitation
F. Spinal Cord Injury Medicine
G. Sports Medicine

XVIII. American Board of Plastic Surgery

A. Plastic Surgery
B. Plastic Surgery within the head and neck
C. Surgery of the Hand

XIX. American Board of Preventive Medicine

A. Aerospace Medicine
B. Addiction Medicine
C. Clinical Informatics
D. Health Care Administration, Leadership, and Management
E. Medical Toxicology
F. Occupational and Environmental Medicine
G. Public Health and General Preventive Medicine
H. Undersea and Hyperbaric Medicine

XX. American Board of Psychiatry and Neurology

A. Addiction Psychiatry

B. Brain Injury Medicine
C. Child And Adolescent Psychiatry
D. Clinical Neurophysiology
E. Consultation Liaison Psychiatry
F. Epilepsy
G. Forensic Psychiatry
H. Geriatric Psychiatry
I. Neurocritical Care
J. Neurodevelopmental Disabilities
K. Neurology
L. Neurology with special qualification in Child Neurology
M. Neurodevelopmental Disabilities
N. Neuromuscular Medicine
O. Pain Management
P. Sleep Medicine
Q. Vascular Neurology

XXI. American Board of Radiology

A. Diagnostic Radiology
B. Interventional Radiology and Diagnostic Radiology
C. Medical Physics (Diagnostic, Nuclear, Therapeutic)
D. Neuroradiology
E. Nuclear Radiology
F. Pain Medicine
G. Pediatric Radiology
H. Radiation Oncology
I. Radiology

XXII. American Board of Surgery

A. General Surgery
B. Complex General Surgical Oncology
C. Pediatric Surgery
D. Surgery
E. Surgical of the Hand
F. Surgical Critical Care
G. Vascular Surgery

XXIII. American Board of Thoracic Surgery

A. Thoracic and Cardiac Surgery
B. Congenital Cardiac Surgery

XXIV. American Board of Urology, Inc.

A. Urology
B. Pediatric Urology
C. Urogynecology Reconstructive Pelvic Surgery

American Osteopathic Association Boards (AOA)

I. American Osteopathic Board of Anesthesiology

A. Anesthesiology
B. Critical Care Medicine
C. Pain Management
D. Pediatric Anesthesiology

II. American Osteopathic Board of Dermatology

A. Dermatology
B. Dermatopathology
C. MOHS-Micrographic Surgery

D. Pediatric Dermatology

III. American Osteopathic Board of Emergency Medicine

A. Emergency Medical Services
B. Emergency Medicine
C. Hospice and Palliative Care Medicine
D. Medical Toxicology
E. Sports Medicine
F. Undersea and Hyperbaric Medicine

IV. American Osteopathic Board of Family Practice

A. Addiction Medicine
B. Correctional Medicine
C. Hospice and Palliative Care Medicine
D. Family Medicine
E. Geriatric Medicine
F. Pain Medicine
G. Sports Medicine
H. Undersea and Hyperbaric Medicine

V. American Osteopathic Board of Internal Medicine

A. Addiction Medicine
B. Cardiology
C. Clinical Cardiac Electrophysiology
D. Correctional Medicine
E. Critical Care Medicine
F. Endocrinology
G. Gastroenterology
H. Geriatric Medicine
I. Hematology
J. Hematology/Oncology
K. Hospice and Palliative Care Medicine
L. Infectious Disease
M. Internal Medicine
N. Interventional Cardiology
O. Nephrology
P. Oncology
Q. Pain Medicine
R. Pediatric and Adult Allergy & Immunology
S. Pulmonary Disease
T. Rheumatology
U. Sleep Medicine
V. Sports Medicine
W. Undersea and Hyperbaric Medicine

VI. American Osteopathic Board of Neurology and Psychiatry

A. Addiction Medicine
B. Child And Adolescent Neurology
C. Child And Adolescent Psychiatry
D. Geriatric Psychiatry
E. Hospice and Palliative Care Medicine
F. Neurology
G. Neurophysiology
H. Psychiatry
I. Sleep 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. Female Pelvic Med/Reconstructive Surgery
B. Gynecologic Oncology
C. Gynecology
D. Maternal And Fetal Medicine
E. Obstetrics
F. Obstetrics And Gynecology
G. Reproductive Endocrinology & Infertility

X. American Osteopathic Board of Ophthalmology and Otolaryngology

A. Ophthalmology
B. Otolaryngology / Facial Plastic Surgery
C. Otolaryngic Allergy
D. Sleep Medicine

XI. American Osteopathic Board of Orthopedic Surgery

A. Orthopedic Surgery
B. Hand Surgery
C. Orthopedic Sports Medicine

XII. American Osteopathic Board of Pathology

A. Anatomic Pathology
B. Chemical Pathology / Laboratory Medicine
C. Dermatopathology
D. Forensic Pathology

XIII. American Osteopathic Board of Pediatrics

A. Neonatology
B. Pediatric Allergy and Immunology
C. Pediatrics
D. Sports Medicine

XIV. American Osteopathic Board of Physical Medicine & Rehabilitation

A. Physical Medicine & Rehabilitation
B. Hospice and Palliative Care Medicine
C. Pain Medicine
D. Sports Medicine

XV. American Osteopathic Board of Preventive Medicine

A. Aerospace Medicine
B. Correctional Medicine
C. Occupational Medicine
D. Public Health/General Preventive Medicine
E. Undersea and Hyperbaric Medicine

XVI. American Osteopathic Board of Proctology

A. Proctology

XVII. American Osteopathic Board of Radiology

A. Diagnostic Radiology
B. Neuroradiology
C. Pediatric Radiology
D. Radiation Oncology
E. Radiology
F. Vascular & Interventional Radiology

XVIII. American Osteopathic Board of Surgery

A. Cardiothoracic Surgery
B. General Surgery
C. Neurological Surgery
D. Plastic and Reconstructive Surgery
E. Surgery
F. Surgical Critical Care
G. Urological Surgery
H. Vascular Surgery

American Board of Dental Sleep Medicine

A. Dental Sleep Medicine

American Academy of Pediatrics (AAP)

A. Pediatric Heart Surgery
B. Pediatric Neurosurgery
C. Pediatric Orthopedics
D. Pediatric Urology

American Board of Oral and Maxillofacial Pathology

A. Oral Pathology

American Board of Oral and Maxillofacial Surgery

A. Oral and Maxillofacial Surgery
B. Oral Pathology

American Board of Orthodontics

A. Orthodontics

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. Acupuncturist
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. General Dentistry
XIII. General Practice
XIV. Licensed Clinical social Worker (LCSW)
XV. Licensed Professional Counselor
XVI. Licensed Senior Psychological Examiner (LSPE)
XVII. Marriage and Family Therapist
XVIII. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
XIX. Midwife (CNM)
XX. Neuropsychology (Ph.D.)
XXI. Nurse (RN)
XXII. Nurse Clinician
XXIII. Nurse Practitioner
XXIV. Nurse Practitioner, Acute Care
XXV. Nurse Practitioner, Adult Health
XXVI. Nurse Practitioner, Family Practice
XXVII. Nurse Practitioner, Gerontology and Adult Health
XXVIII. Nurse Practitioner, Neonatal
XXIX. Nurse Practitioner, Pediatrics
XXX. Nurse Practitioner, Psychological/Mental Health
XXXI. Nurse Practitioner, Women's Health
XXXII. Nutrition
XXXIII. Occupational Therapy (OT)
XXXIV. Optometry
XXXV. Pastoral Counselor
XXXVI. Pediatric Anesthesiology
XXXVII. Pediatric Genetics
XXXVIII. Pediatric Ophthalmology
XXXIX. Pediatric Plastic Surgery
XL. Pharmacist – Clinical
XLI. Pharmacist – Immunizing
XLII. Physical Therapist (PT)
XLIII. Physician Assistant (PA)
XLIV. Physician Assistant – Surgical Assist
XLV. Professional Counselor
XLVI. Prosthetist/Orthotist
XLVII. Psychiatrist
XLVIII. Psychologist or Psychoanalyst
XLIX. Psychology (Ph.D)
L. Speech Pathology/Speech Therapy (ST)
LI. Therapeutic Optometry

5. Accrediting Bodies We Recognize

- 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) now QUAD A
- American Association for Marriage and Family Therapy (AAMFT)

- American Association of Critical-Care Nurses (AACN)
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABCOP)
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Speech-Language-Hearing Association (ASHA)
- Board of Certification/Accreditation (BOC)
- Certified Urgent Care Program (CUC)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Commission on Ambulatory and Urgent Care Quality (CAUCQ)
- 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 Facilities Accreditation Program (HFAP)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- 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)
- Pediatric Nursing Certification Board
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The Center for Improvement in Healthcare Quality (CIHQ)
- 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)

D. Practice Site/Medical Record Standards

Practice Site Standards

BlueCross BlueShield of Tennessee has adopted practice site standards for all credentialed practitioners that provide ambulatory care to our members. These standards were developed to ensure members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) will review all practitioner office site quality complaints/referrals to ensure practitioner offices meet these standards. Main sources for the Office Site Quality referrals may include member complaints, onsite auditors (e.g., credentialing, clinical quality assurance, internal audit) or other internal or external sources. Credentialed practitioners will be advised in writing about specific complaints received concerning the quality of the office site. Credentialed practitioners with two office quality complaints within a six-month period, including, but not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to the Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within 60 days of the second member complaint. CRM will investigate the severity of all complaints received. We may also act on only one complaint if determined necessary.

Primary care provider (PCP) practice sites and OB/GYN sites, not previously reviewed and currently occupied by a network provider, will be evaluated prior to, or within 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 the Clinical Risk Management Committee and re-audited within approximately six 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 approximately six months.

We have adopted the current established site review standards listed below. Compliance with all required elements noted with an asterisk (*) and an overall score of 80% is required to meet these site review standards.

These standards are subject to change and revisions will be posted in quarterly updates.

*Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the provider on call. Review of after-hours coverage is documented by Clinical Quality Assurance on a separate tool.

Site Review Standards

1. *The office must be wheelchair accessible.
2. *The office must be clean and organized, with adequate exam room and waiting room space.
3. *The office must have adequate lighting in all patient areas such as the entry way, waiting room, restrooms, and treatment areas.
4. *Exam rooms must be designed for patient privacy.
5. There should be evidence of compliance with our appointment availability standards for routine and urgent care.
6. *There must be an individual medical record for each patient.
7. *Current medical records must be available at the site where services are provided and readily accessible.
8. *Medical records must be kept in a secure location. Sites with electronic medical records should provide evidence of a secure off-site record retention/recovery process.
9. *There must be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
10. *There must be evidence of a fire safety/emergency action plan with evidence of staff education. In locations with 10 or more employees, the plan must be documented in writing.
    - At a minimum, the fire safety/emergency plan should include:
        - Well-marked evacuation routes that are clear and unobstructed
        - Working fire extinguishers and smoke detectors
        - Compliance with local fire codes
11. *Emergency supplies and procedures must be available for scope of practice.
    - At a minimum, the emergency supplies and procedure requirements should include:
        - Epinephrine and oxygen.
        - Delivery kit in addition to epinephrine and oxygen for obstetrical sites and family practice sites who provide care for pregnancy.
        - Crash cart and oxygen at sites that perform stress tests or services that require sedation.
12. *The office must have infection control procedures that include appropriate disposal of bio- hazardous material. Hand washing facilities must be in/near treatment rooms and Occupational Safety and Health Administration (OSHA) standards and Material Safety Data Sheet (MSDS/SDS) information must be available to staff.
13. *There must be a process for the appropriate disposal of needles and other sharps.
14. There should be a process for inventory control of all stock and sample medications including evidence of regular monitoring of expiration dates.
15. *There must be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
16. *Controlled substances must be maintained in a locked area.

17. *Evidence of CLIA registration with a site-specific address is required for any practice where labs are performed.
18. *If radiology services are provided, a current state inspection compliance notice must be posted with the date of the last inspection.
19. Radiology techniques should be posted near the radiology equipment if not generated by radiology equipment.
20. There should be a sign posted that physician extenders may provide care, where applicable.
21. Professional staff should be licensed appropriately with evidence of licensure on file.
22. Member rights and responsibilities should be posted or otherwise made available to members.

Comprehensive Medical Record Standards

Network providers 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 5% of credentialed primary care practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with the practitioner or practitioners representative if applicable. In addition, medical record reviews will be performed during the annual Healthcare Effectiveness Data and Information Set (HEDIS®) project and analysis performed to identify providers with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed provider 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 must be legible.
2. Member identification must be on each page of the record.
3. Each recorded chart entry must be dated and identified by the author. Stamped signatures aren't acceptable.
4. The medical records should be readily accessible to the provider during normal office hours.

Documentation

5. All medical records must 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** must be consistently documented and prominently displayed in all medical records.
7. An initial history and physical exam should be documented for new patients within 12 months of the member first seeking care, or within three 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 six should be documented.
8. Each medical record must contain an updated list of medications the member is taking, or documentation that the member isn't currently taking any medications.
9. Each medical record must contain tobacco, alcohol, and/or substance use history (for members 12 years and over and seen three 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 the visit. Clinical assessment and a physical exam should be documented and correspond to the 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 exam should be recorded.
14. Rationale for treatment decisions should be medically appropriate and substantiated by documentation in the record, with lab tests performed at appropriate intervals.
15. Records should substantiate the member's clinical problems and treatment so another practitioner can determine the member's overall clinical course under the reviewed provider'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 visit.
17. Medical records should contain documentation of appropriate use of consultants, which includes behavioral health practitioners, and documentation of medical services performed by a referral specialist/provider.
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 and Preventive Care

19. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with *The U.S. Preventive Services Task Force Guide to Clinical Preventive Services or the American Academy of Pediatrics*, as applicable.
20. Care for high-risk conditions should be documented in accordance with our *Clinical Practice Guidelines* (CPG's).
21. There should be documentation of member education/instructions.

TennCare Kids Medical Record Standards

Clinical personnel review medical records of primary care providers that provide preventive care to members under the age of 21 to evaluate compliance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements and share additional education and resources. Reviews are performed every two 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% threshold required for compliance with TennCare Kids standards shall receive a letter requesting information about actions taken to improve performance and documentation because of this review. A re-audit will be scheduled within 12 months of receiving the practitioner response.

Practitioners that fail to meet the minimum compliance standard on re-audit will receive additional education about deficiencies and a re-audit planned within 12 months. Failure to meet the compliance threshold with second re-audit will result in a referral to the Clinical Risk Management Committee for evaluation and communication of a Practice Improvement Plan.

Age-appropriate elements, identification of risk factors and 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 12 and 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 practitioners, or for ancillary care because of problems identified.

Facility Site Standards

Non-accredited facilities applying for initial credentialing with BlueCross BlueShield of Tennessee networks must meet and maintain compliance with the site standards listed below.

Noncompliant sites for currently credentialed providers will be referred to the BlueCross BlueShield of Tennessee Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed providers until BlueCross BlueShield of Tennessee facility site standards are met.

Physical Assessment

1. The facility must be wheelchair accessible.
2. The facility should be clean and organized with adequate lighting throughout, and 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 facilitates follow-up treatment.

Safety

8. Emergency supplies and procedures should be available for the scope of practice.
9. Policies and procedures should be available and reviewed annually regarding administrative, operational, safety and 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 Occupational Safety and Health Administration (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 labs are 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 techniques 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 with evidence of regular monitoring of expiration dates.
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 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 the credentialing process for independent providers.
    b. Completing credentialing functions according to state, federal and NCQA standards.
    c. Using the current license, relevant training and experience, current competence, and privileges at a hospital in the credentialing process.
23. A Credentialing representative will audit the facility's files to ensure the credentialing process meets the above criteria.

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XVIII. CoverKids

A. Introduction

BlueCare Tennessee administers the CoverKids program on behalf of the Division of TennCare. "CoverKids" means the State Child Health Plan under Title XXI of the Social Security Act State Children's Health Insurance Program. Effective July 1, 2016, CoverKids is supported by BlueCare Tennessee's CoverKids Network. Effective January 1, 2021, Cover Kids is supported by the BlueCare Network. The CoverKids program provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over. Effective January 1, 2021, the pharmacy benefit will be administered through the PBM (OptumRx) that contracts directly with TennCare.

The CoverKids plan provides free, comprehensive health coverage for qualifying children under age 19 years and pregnant women. "CoverKids Pregnant Women" (formerly referred to as "CoverKids Pregnant Women/Unborn Children") provides coverage for the unborn children of pregnant women with no source of coverage, who meet the CoverKids eligibility requirements. 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 (100%).

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 Provider. If a CoverKids patient wishes to obtain a second opinion, please refer him/her to a BlueCare Network Provider. If a BlueCare 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 or Pregnant women over the age of 18 years;
- A Tennessee resident;
- U.S. citizen or qualified legal alien;
- Not eligible for TennCare; and
- Household income up to 250 percent of federal poverty level.

C. Application

1. An application may be filed online or by phone through the FFM at 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 TennCareConnect at 1-855-315-0669.
4. A paper application with a signed cover page* may be mailed to TennCareConnect at P.O. Box 305240, Nashville, TN 37202-5240.

   Note: Providers must report ALL non-live births to TennCareConnect.

* The paper application and cover page can be found online at https://www.tn.gov/coverkids/coverkids/application.html or by calling 1-855-259-0701.

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

E. Benefits

CoverKids Benefits	BENEFIT LEVEL		
	1	2	3
Office/Outpatient Services			
Primary Care Visit ➢ Office visits with family practice, general practice, internal medicine, OB/GYN, pediatrics, and walk in clinics ➢ Includes nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care Provider	$15 Co-Pay	$5 Co-Pay	No Co-Pay
Specialist Visit and Outpatient Surgery ➢ Office visits with any specialty Provider ➢ Outpatient surgeries including invasive diagnostic services (e.g. colonoscopy)- **Single co-pay per date of service**	$20 Co-Pay	$5 Co-Pay	No Co-Pay

CoverKids Benefits	BENEFIT LEVEL		
	1	2	3
Behavioral Health (Mental Health and Substance Abuse) Services ➢ Office visits ➢ Outpatient Mental health and substance abuse - **Single co-pay per date of service**	$15 Co-Pay	$5 Co-Pay	No Co-Pay
Chiropractors ➢ **Only covered for children under age 19**	$15 Co-Pay	$5 Co-Pay	No Co-Pay
Rehabilitation and Therapy Services ➢ Including Speech, Physical and Occupational ➢ Limited to 52 visits per therapy type per Calendar Year	$15 Co-Pay	$5 Co-Pay	No Co-Pay
Pharmacy - Benefits managed by OptumRx			
Refer to website: https://www.optumrx.com/oe_coverkids/landing			
Non-Emergency Care			
Emergency Room Visit deemed as NOT a True Medical Emergency ➢ Facility (Medical & Behavioral Health [Mental Health, Alcohol and Drug Abuse]) ➢ MUST be an In Network Provider. If Out of Network Provider, CoverKids will NOT pay.	$50 Co-Pay	$10 Co-Pay	No Co-Pay
Inpatient Stays			
Inpatient Facility (Medical and Behavioral Health [Mental Health, Alcohol and Drug Abuse]) ➢ Co-Pay waived if readmitted within 48 hours of initial visit for same episode of illness or injury ➢ Rehabilitation services ➢ Mental Health, Alcohol and Drug Abuse Treatment	$100 Co-Pay per admission	$5 Co-Pay per admission	No Co-Pay
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 ➢ Including bifocal or trifocal ➢ Limited to one per Plan Year	$15 Co-Pay $85 Max Benefit	$15 Co-Pay $85 Max Benefit	No Co-Pay
Prescription Contact Lenses in lieu of Eyeglass Lenses ➢ Limited to one per Plan Year	$15 Co-Pay $150 Max Benefit	$5 Co-Pay $150 Max Benefit	No Co-Pay
Frames ➢ Limited to every 2 Plan Years	$15 Co-Pay $100 Max Benefit	$5 Co-Pay $100 Max Benefit	No Co-Pay

The following grid identifies CoverKids services that do NOT require a co-pay:

The following services do NOT require a Co-Pay
Preventive Care
Office Visits ➢ Well-baby, well-child visits ➢ Annual physical exam ➢ Annual well-woman exam including, but not limited to, family planning and pap tests ➢ Immunizations ➢ Annual hearing and vision screening ➢ Screenings including colonoscopy, colorectal, labs, nutritional guidance, Sexually Transmitted Disease (STD), cancer and other screenings
Office/Outpatient Services
X-Ray, Lab and Diagnostics ➢ Including reading, interpretation of results, dialysis, radiation, cobalt, and radioisotope therapy ➢ Including MRIs, cat scans and nuclear medicine
Allergy Testing and Allergy Injections
Chemotherapy and Radiation Therapy
Emergency Care
Emergency Room Visit Deemed as an Emergency ➢ Medical and Behavioral Health (Mental Health and Substance Abuse)
Services Received at an Outpatient Facility
Physician Charges (Medical and Behavioral Health [Mental Health and Substance Abuse])
Skilled Nursing Facility ➢ Limited to 100 days per Calendar Year following approved hospitalization
Comprehensive Child and Family Treatment (CCFT)
Maternity Services
Maternity Related Facility and Provider ➢ Maternity Visits prenatal and postpartum care) ➢ Hospital admission for delivery
Other Services
Durable Medical Equipment (DME) ➢ Including prosthetics/orthotics ➢ Hearing aids are limited to 1 per ear per Calendar Year up to the age 5; then 1 per ear every 2 years thereafter
Supplies (31 day supply)
Ambulance - Land and Air ➢ Emergency to the nearest facility ➢ From the scene of an accident to the nearest facility ➢ Facility to facility when medically appropriate
Home Health ➢ Home Nursing Care limited to 125 visits per Calendar Year
Home Infusion Therapy

The following services do NOT require a Co-Pay
Hospice ➢ Co-Pay waived for all services if Member is under hospice care
Diabetic Self-Management Training and Education
Vision Services - These Services are only eligible for Members 18 years and under.
Annual Vision Exam ➢ Including refractive exam and annual glaucoma testing ➢ Must go to an In-Network Provider
Diapers/Training Pants Coverage – This benefit is only eligible for Members until age 2.
➢ Limit to 100 diapers per month from an approved list of types and brands at https://www.tn.gov/tenncare/members-applicants/benefits-services/diapers.html. ➢ Must go to a participating pharmacy listed at tn.gov/tenncare/diapers ➢ Prescription is not required ➢ Parent/Guardian present their child's pharmacy ID card at pharmacy counter of participating locations. ➢ Newborns that haven't received a pharmacy ID card yet, parents can present the mother's pharmacy ID card or the child's Social Security Number.

Covered Services and Limitations on Covered Services

The Plan will pay the 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 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

1. 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.
2. 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.
3. Out-of-Network Providers
   No benefits will be paid for services received from Out-of-Network Providers under this Plan. There are two exceptions to this:

a. There are benefits for Out-of-Network, hospital-based Practitioners in a Network facility.
b. In a true Emergency, there are benefits for Out-of-Network Providers (Facility and Practitioners).

Eligible Services:

1. Practitioner Office Services
   Medically Necessary and Appropriate services in a Practitioner's office.

   a. Covered

      i. 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.
      ii. Injections and medications administered in a Practitioner's office, except Specialty Pharmacy Products.
      iii. Casts and dressings.
      iv. Nutritional guidance and education.
      v. Foot care necessary to prevent the complications of an existing disease state.
      vi. 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.
      vii. Emergency conditions presenting to the Practitioner's Office.
      viii. Pre- and post-natal maternity care, including complications of pregnancy, including the initial diagnosis of a pregnancy.

   b. Exclusions

      i. 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.
      ii. 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.

2. 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).

   a. Covered

      i. 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.
      ii. Recommended and appropriate immunizations (including influenza immunizations).
      iii. 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.

   b. Exclusions

      i. Immunizations needed for foreign travel.
      ii. 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.
      iii. Preventive services not listed as Covered.
      iv. 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).

3. 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).

a. Covered

i. Excision of skin lesions and incisions.
ii. Repair of lacerations.
iii. Removal of foreign bodies from skin, eyes, or orifices.
iv. Sigmoidoscopy, pharyngoscopy, or other endoscopies.
v. Biopsies.
vi. Colposcopy.
vii. Incision and drainage of abscess.
viii. Cyst aspiration.
ix. Joint injection and aspiration.
x. Toenail excision.
xi. Cryosurgery of skin lesions and cervical lesions.
xii. Casting and splinting.

4. 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)(iv) below.

The following criteria must be met before benefits are available for the procedures listed above:

e. Presence of morbid obesity that has persisted for at least five years, defined as either:

i. Body mass index (BMI) exceeding 40; or
ii. More than 100 pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or
iii. BMI greater than 35 in conjunction with the following severe co-morbidities that are likely to reduce life expectancy

- Coronary artery disease; or
- Type 2 diabetes mellitus; or
- Obstructive sleep apnea; or

- Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)
- Low high density lipoprotein cholesterol (HDL less than 40mg/dL)
- Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)
- Current cigarette smoking
- Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test)
- 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)

iv. BMI exceeding 60 for consideration of the Duodenal Switch/Biliopancreatic Bypass procedure.

f. 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.)
g. 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 and his/her associates, and documentation that this evaluating Physician concurs with the recommendation for bariatric surgery.

5. Inpatient Hospital Services

a. Covered

i. 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.
ii. Attending Practitioner's services for professional care.
iii. Observation stays.
iv. Blood/plasma is covered unless free.
v. Maternity and delivery services, including complications of pregnancy.

b. Exclusions

i. Inpatient stays primarily for therapy (such as physical or occupational therapy).
ii. Services that could be provided in a less intensive setting.
iii. Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.
iv. Private duty nursing care

6. 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.

a. Covered

i. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Emergency condition.
ii. Practitioner services.

b. Exclusions

i. Services received for inpatient care or transfer to another facility once medical condition has stabilized, unless Prior Authorization is obtained from the Plan.

7. 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.

a. Covered

i. 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.

b. Exclusions

i. Transportation for the Member's convenience.
ii. Transportation that is not essential to reduce the probability of harm to the Member.
iii. Services when Member is not transported to a facility.

8. 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.

a. Covered

i. Practitioner services.
ii. Outpatient diagnostics (such as x-rays and laboratory services).
iii. Outpatient treatments (such as medications and injections).
iv. Outpatient surgery and supplies.
v. Observations stays.
vi. Rehabilitative therapies.
vii. Maternity and Delivery Services (including complications of pregnancy).

b. Exclusions

i. Vasectomies.
ii. Services that could be provided in a less intensive setting.

9. Behavioral Health

a. Covered

Medically Necessary and Medically Appropriate treatment of behavioral health conditions by a licensed practitioner.

ii. Inpatient including Residential Treatment Center and outpatient services for care and treatment of mental health disorders and substance use disorders*.
iii. Applied Behavior Analysis (ABA) services*
iv. Continuous Treatment Team (CTT) *
v. Comprehensive Child and Family Treatment (CCFT) *
vi. Methadone Medication Assisted Treatment for SUD
vii. Buprenorphine Medication Assisted Treatment for OUD
viii. Psychological Testing*
ix. Transcranial Magnetic Stimulation (TMS) *
x. Electroconvulsive Therapy (ECT) (as of July 1, 2024, no prior authorization required)*

*Prior Authorization is required for Inpatient Services as well as some Outpatient Services and procedures.

b. Exclusions

i. Religious counseling
ii. Marriage and family counseling without a behavioral health diagnosis
iii. Vocational and educational training and/or services
iv. Custodial or domiciliary care
v. Services related to Learning Disorders
vi. Any care in lieu of legal involvement or incarceration unless medically necessary
vii. Hypnosis or regressive hypnotic techniques
viii. Charges for missed appointments, completion of forms, or other administrative services
ix. Services that could be provided in a less intensive setting
x. Any International Classification of Disease (ICD) codes that are not included in the appropriate code range

10. 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

a. Covered

i. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing
ii. Services or supplies for the evaluation of infertility
iii. Medically Necessary and Appropriate termination of a pregnancy
iv. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion

b. Exclusions

i. 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.
ii. Services or supplies for the reversals of sterilizations.
iii. Induced abortion unless: the pregnancy itself would place the mother in danger of death. Abortions are a covered service only when the guidelines listed in Section XIII. ASH are met pursuant to applicable federal and state laws. A certificate of medical necessity must be

completed by the physician and attached to the claim submitted to BlueCare Tennessee for payment.

11. Reconstructive Breast Surgery
Medically Necessary and Appropriate surgical procedures intended to restore normal form or function.

    a. Covered

        i. 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.

    b. Exclusions

        i. Services, supplies or prosthetics primarily to improve appearance
        ii. Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance
        iii. Surgeries and related services to change gender
        iv. Any other reconstructive surgery

12. 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.

    a. Covered

        i. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units
        ii. The attending Practitioner's services for professional care
        iii. 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

    b. Exclusions

        i. Custodial, domiciliary or private duty nursing services
        ii. Skilled Nursing services not received in a Medicare certified skilled nursing facility.
        iii. Services for cognitive rehabilitation
        iv. Services which were not authorized by the Plan

13. 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.

    a. Covered

        i. 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.
        ii. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services.

            - 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.

        iii. 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.

iv. 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.
v. 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.

b. Exclusions

i. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.
ii. Enhancement therapy which is designed to improve the Member's physical status beyond the pre-injury or pre-illness state.
iii. 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.
iv. 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.
v. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs.
vi. 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.
vii. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit.

14. Organ/Tissue Transplants
All organ/tissue transplants require **prior authorization**. It is critically important to both the Provider and Member that CoverKids be contacted as soon as the Member has completed a transplant evaluation and Practitioner has deemed him/her as an appropriate candidate to be listed for transplant. Providers should contact CoverKids to verify participating facilities before referring Members for transplant evaluation or services, which could result in a transplant (e.g., high dose chemotherapy). To initiate a transplant authorization, call Cover Kids at 1-888-325-8386.

Note: *CoverKids does not cover hair transplants.*

Medically Necessary and Appropriate services and supplies provided to the Member, when the Member is the recipient of the following organ/tissue transplant procedures:

- Kidney
- Pancreas
- Kidney/Pancreas
- Heart
- Heart/Lung
- Lung
- Liver
- Small bowel/multi-visceral
- Bone marrow/Stem cell
- Total or near Total Pancreatectomy
- Autologous Pancreatic Islet Cell
- CAR-T Therapy

a. 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:

i. Medically Necessary and Appropriate services and supplies, otherwise covered under this program;

ii. 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.

- 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.
- 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.
- The aggregate limit for travel expenses is $15,000 per covered procedure.

iii. Donor Organ/Tissue 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/tissue from donor's body; (3) preservation of the organ/tissue; and (4) transportation of the organ/tissue 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/tissue are also covered under this benefit. Complications of donor organ/tissue procurement are not covered. The cost of Donor Organ/Tissue Procurement is included in the total cost of the Organ/Tissue Transplant.

Conditions/Limitations

The following limitations and/or conditions apply to services, supplies or charges:

- 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.

b. Exclusions
The following services, supplies and charges are not covered under this section:

i. If no prior authorization obtained, the transplant and related services will not be covered;
ii. Services or supplies not specified as Covered Services under this section;
iii. Any attempted covered procedure that was not performed, except where such failure is beyond the Member's control;
iv. Non-Covered Services;
v. 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;
vi. Any non-human, artificial or mechanical organ/tissue;
vii. Payment to an organ/tissue donor or the donor's family as compensation for an organ/tissue, or payment required to obtain written consent to donate an organ/tissue;
viii. Donor services including screening and assessment procedures which have not received prior authorization, or services utilized to verify the health of the donor;
ix. Removal of an organ/tissue from a Member for purposes of transplantation into another person, except as covered by the Donor Organ/Tissue Procurement provision as described above;
x. 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
xi. Other non-organ/tissue 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.

15. 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.

a. Covered

i. 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
ii. must be started within 3 months and completed within 12 months of the accident.
iii. Extraction of impacted wisdom teeth.
iv. Orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function.
v. 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:

- Complex oral surgical procedures which have a high probability of complications due to the nature of the surgery;
- Concomitant systemic disease for which the patient is under current medical management and which significantly increases the probability of complications;
- Mental illness or behavioral condition which precludes dental surgery in the office;
- Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or
- 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.

b. Exclusions

i. 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.
ii. 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.
iii. Dental procedures, except as otherwise indicated in the Member's healthcare benefits plan.

16. Temporomandibular Joint Dysfunction (TMJ)
Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

a. Covered

i. Diagnosis and management of TMJ or TMD.
ii. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.
iii. 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.
iv. Orthodontic treatment if medically necessary.

b. Exclusions

i. 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.

ii. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

17. Diagnostic Services
Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

a. Covered

i. Non-routine Diagnostic Services ordered by a Practitioner.
ii. All other Diagnostic Services ordered by a Practitioner.

b. Exclusions

i. Diagnostic Services which are not Medically Necessary and Appropriate.
ii. Diagnostic Services not ordered by a Practitioner.

18. 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 Provider-Administered Specialty Pharmacy Products (bcbst.com). Please review the listing to determine which drugs may require Prior Authorization or have other limitations.

a. Covered

i. Provider-administered Specialty Drugs as identified on the Provider-Administered Specialty Pharmacy Products List (includes administration by a qualified Provider).

b. Exclusions

i. Self-administered Specialty Drugs.

19. 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.

a. Covered

i. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
ii. 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.
iii. Rigid contact lenses and intrastromal corneal ring segments (ICRS) with diagnosis of keratoconus.
iv. One vision exam (including refractive exam and glaucoma testing) per Plan Year. Vision exam must be provided by a Network Provider.
v. One set of lenses (including bi-focal, tri-focal, etc.) per Plan Year.
vi. Prescription contact lenses in lieu of eyeglasses.
vii. One set of eyeglass frames every 2 Plan Years.
viii. Approved optical services, supplies and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories participating in the BlueCare Network. Prior approval is required for any other services or visual aids.

b. Exclusions

i. Surgeries to correct refractive errors of the eyes.
ii. Eye exercises and/or therapy.
iii. Visual training
iv. Charges for vision testing exams, lenses, frames or contacts ordered while covered but not delivered within 60 days after coverage is terminated.
v. Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowed for regular lenses.
vi. Charges filed for procedures the administrator determines to be special or unusual, such as orthoptics, vision training, subnormal vision aids, aniseikonia lenses, tonography, etc.

vii. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
viii. Charges in excess of the Maximum Allowable Charge.

20. 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.

a. Covered

i. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total 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 Member will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.
ii. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment.
iii. Supplies and accessories necessary for the effective functioning of covered durable medical equipment.
iv. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging.

b. Exclusions

i. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment.
ii. Unnecessary repair, adjustment or replacement or duplicates of any such equipment.
iii. Supplies and accessories that are not necessary for the effective functioning of the covered equipment.
iv. Items to replace those which were lost, damaged, stolen or prescribed as a result of new technology.
v. Items which require or are dependent on alteration of home, workplace or transportation vehicle.
vi. Motorized scooters, exercise equipment, hot tubs, pool, saunas.
vii. "Deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed medical care will determine the benefit.

21. 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.

a. Covered

i. Blood glucose monitors; Test strips for blood glucose monitors, as listed on the formulary.
ii. Insulin.
iii. Syringes.
iv. Lancets.
v. Podiatric appliances for prevention of complications associated with diabetes.
vi. 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.
vii. Outpatient self-management training and education, including medical nutrition counseling. Available initially and when condition changes.
viii. Visual reading and urine test strips.
ix. Injection aids.
x. Insulin pumps, infusion devices and appurtenances.
xi. Oral hypoglycemic agents.
xii. Glucagon emergency kits.

b. Exclusions

i. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

22. Prosthetics/Orthotics
Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ/tissue 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.

a. Covered

i. The initial purchase of surgically implanted prosthetic or orthotic devices.
ii. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment.
iii. Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order.
iv. The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging.
v. The initial purchase of artificial limbs or eyes,
vi. The first pair of eyeglasses or contact lenses prescribed as a result of a cataract operation and obtained with 6 months following the surgery.
vii. Cochlear Implantation – using FDA approved implants and provided all the following criteria are met:

For Children age 18

- Diagnosis of post-lingual profound deafness;
- Patient has achieved little or no benefit from a hearing aid;
- 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;
- Patient has cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and
- Patient has no contraindications to surgery.

For Children (Ages 2-17)

- Diagnosis of bilateral profound sensorineural deafness; and
- 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 audiometry 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.

viii. Foot orthotics are a covered expense for the following:

- 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.
- 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:
- Peripheral neuropathy with evidence of callus formation; or
- History of pre-ulceratic calluses; or
- History of previous ulceration, or
- Foot deformity, or
- Previous amputation of the foot or part of the foot; or

ix. Poor circulation. Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care
x. Prosthetic shoes, limited to one per lifetime, that are an integral part of prosthesis and
xi. Medically Necessary, as determined by the claims administrator, for Members with a partial foot
xii. Ankle orthotics, foot orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses when
xiii. Medically Necessary, as determined by the claims administrator.
xiv. Hearing aids. Limited to 1 per ear per Calendar Year up to age 5; then 1 per ear every 2 years thereafter.

b. Exclusions

i. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.
ii. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
iii. The replacements of contact lenses after the initial pair have been provided following cataract surgery.

23. 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 health care services.

a. Covered

i. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse.
ii. Home infusion therapy.
iii. 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.

b. Exclusions

i. 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.
ii. Custodial, domiciliary or private duty nursing services.
iii. Dietary guidance.
iv. Services that were not authorized by the Plan.

24. Hospice
Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less.

a. Covered

i. 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.

b. Exclusions

i. 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.

25. 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.

a. Covered

i. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility.

ii. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.

b. Exclusions

i. 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;
ii. Supplies used in the home setting or otherwise for self-use, unless prescribed by a Practitioner and are both Medically Necessary and Appropriate.

26. Prescription Drug Program
Effective January 1, 2021, CoverKids Pharmacy Benefits Manager is OptumRX. Please visit https://www.optumrx.com/oe_coverkids/landing to review the CoverKids formulary and pharmacy benefits. The OptumRX CoverKids Member Services and Prior Authorization line is 844-568-2179 and fax is 844-403-1029.

27. Phenylketonuria (PKU)
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

Note: The Plan will retain any refunds, reimbursements or other payments representing a return of monies paid for Covered Services under this section.

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.
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) 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 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/tissue 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.
26. Sperm preservation.
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. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.
33. 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.

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 prior authorization:

- Autonomic Nervous System Testing
- Implantable Pain Pumps/Devices
- Joint Replacements and Spinal Procedures
- Orthognathic Surgery
- Proton Beam Therapy for age 21 years and older
- Radiofrequency Ablation/Facet Neurotomy
- All services performed by a plastic specialist, including but not limited to:
  - Abdominoplasty/Panniculectomy
  - Blepharoplasty
  - Breast Reduction
  - Reconstructive Repair Pectus Excavatum
  - Vein Ligation
- All Bariatric Surgeries
- Diagnostic Testing/Laboratory Services - Select high-cost lab testing codes require prior authorization. A full listing of the laboratory testing codes requiring prior authorization can be viewed online at https://bluecare.bcbst.com/forms/Provider%20Forms/High_Cost_Lab_Prior_Authorization_List.pdf.

Specialty Pharmacy

Certain high risk/high-cost specialty pharmacy medications administered in any setting other than inpatient require prior authorization. This authorization requirement applies to all Provider types including home infusion therapy Providers and hospitals providing outpatient infusions and injections. A complete listing of CoverKids specialty pharmacy medications can be viewed online at Provider-Administered Specialty Pharmacy Products (bcbst.com). Note: Some specialty pharmacy medications may require an associated inpatient hospital stay to administer the medication. If an inpatient stay is needed, please fax authorization requests to BlueCare Utilization Management (UM) at **1-800-292-5311** or call **1-888-423-0131**. Select **option 9** to be transferred to the UM team.

Durable Medical Equipment (DME)

As of March 6, 2026, the DME network transitioned to CareCentrix. HIT and O&P services are excluded from this transition. Provider may contact CareCentrix via the **Call Center at 833-715-7767**.

Prior Authorization is required on all Durable Medical Equipment (DME), and Orthotics and Prosthetics (O&P) provided by a DME/O&P Provider with a cost of more than $500 per unit (with some exceptions as noted below).

DME codes and supplies that do require prior authorization (regardless of cost) are listed below:

- Exclusions specified by TennCare (per TennCare Rules)
- Miscellaneous DME codes
- All hospital beds, mattresses, and accessories codes
- Prosthetics and accessories (Mastectomy prosthetic codes don't require authorization due to Tennessee Code Ann. § 56-7-2507)
- Wheelchairs and accessories
- All Repairs and Replacements (with the exception of CRT repairs)
- Labor Charges
- Incontinence products quantity over 200 (quantities over 800 for (A4335) wipes)
- All enteral formula and oral formula [does not include Total Parenteral Nutrition (TPN)]

- Equipment rentals (This exception does not include the rental of apnea monitors, bedside commodes, humidifiers, phototherapy (Bili-lights), pulse oximeters and nebulizers).
- OON Providers: Requests from providers with an out of network status or pay as par status requires prior authorization.

DME codes and supplies that do not require prior authorization (regardless of cost) are listed below:

- Surgical Codes should be billed with the surgical procedure, if a DME item is used within the procedure prior authorization is not required for the DME item. Please refer to the Outpatient (OP) prior authorization list for the surgical procedure.
- No authorization is required for Bath/Shower Equipment/Supplies
- No authorization is required for Upper Extremity Orthotics
- No authorization is required for all Diabetic equipment/supplies (including all Continuous Glucose Monitors (CGM) and Insulin pumps)
- No authorization is required for Ankle Foot Orthotics (AFO)
- No authorization is required for compression garments/stockings.
- No authorization is required for hearing aids, vision and cochlear implants for under 21 years of age for BlueCare/TennCare Select or under 19 years of age for CoverKids (except for V2025, V2762, V2781-these require authorization)
- No authorization is required for supplies (examples are wound, trach, foley, ostomy supplies, etc.)
- CRT Repairs

Equipment Providers

An electric breast pump can be provided with a Physician order and by completing the information at https://aeroflowbreastpumps.com/qualify-through-insurance

Codes for incontinence supplies and products listed below:

Note: Incontinence products only covered for members age 4 and over if needed for a medical condition (See TennCare Rule 1200-13-13-.10(3)(b)17.(iii), except Infant Diapers as described in Rule. 04).

Note: Quantities >200 require prior authorization submitted for the codes listed below. Beginning 5/1/2024 quantities >800 for wipes (A4335) will require review for medical necessity.

A4335	Incontinence supply; misc.	T4531	Pediatric, small/medium, pull-on
A4335SC	Diaper wipes/disposable washcloth	T4532	Pediatric, large, pull-on
A4554	Disposable underpads, any size	T4533	Youth, brief/diaper
T4521	Adult, small, brief/diaper	T4534	Youth, pull-on
T4522	Adult, medium, brief/diaper	T4535	Liner/shield/guard/pad/undergarment
T4523	Adult, large, brief/diaper	T4536	Pull-on, reusable, any size
T4524	Adult, extra-large, brief/diaper	T4537	Protective underpad, reusable, any size
T4525	Adult, pull-on, small	T4539	Diaper/brief, reusable
T4526	Adult, pull-on, medium	T4540	Protective underpad, reusable, chair size
T4527	Adult, pull-on, large	T4541	Disposable underpad, large
T4528	Adult, pull-on, extra large	T4542	Disposable underpad, small
T4529	Pediatric, small/medium, brief/diaper	T4543	Brief/Diaper, Bariatric
T4530	Pediatric, large, brief/diaper	T4544	Adult sized pull up diapers

Complex Rehab Technology (CRT)

For Complex Rehabilitation Technology, all codes/line items to be billed must be provided to pre-review for billable codes and provide coverage determinations for services. For DME to be reviewed as CRT you must complete the CRT DME Authorization Form with the required information. Forms are located on BCBST.com in the provider section. Forms | Providers | BlueCare Tennessee (bcbst.com)

Prior authorization isn't required for repairs of such technology or equipment unless:

- The repairs are covered under a manufacturer's warranty,
- The cost of the repairs exceeds the cost to replace the CRT or manual wheelchair; OR
- The CRT or manual wheelchair in need of repair is subject to replacement because the age of the CRT or manual wheelchair exceeds, or is within one year of the expiration of, the recommended lifespan of the CRT or manual wheelchair.

The Tennessee General Assembly recently passed legislation with new coverage guidelines for the repair of Complex Rehabilitation Technology (CRT), including manual and power wheelchairs. These guidelines take effect July 1, 2024.

Beginning July , we'll cover:

- Repairs provided by an authorized CRT equipment supplier.
- At least one preventative maintenance visit per year provided by an authorized CRT equipment supplier. As part of this visit, we'll cover related costs, including parts and services, labor, and the diagnostic and evaluation time required.

A qualified technician employed by the authorized CRT technology supplier must perform the preventive maintenance according to the manufacturer's guidelines and document and maintain a record of the services provided. Our members don't have to schedule a separate visit for preventive maintenance – CRT suppliers can perform preventive maintenance during visits for unrelated services.

Other CRT Coverage Policies

Medical documentation or proof for the continued need for repair or preventive maintenance isn't required for coverage. We'll also reimburse telehealth visits for CRT for dates of services on or after July 1. Please note, we may still require documentation of a medica necessity determination for CRT.

For more information about these changes, please review the legislation here.

Home Health Services

- All Home Health Services require prior authorization

Behavioral Health (BH) Services

The following BH services require a prior authorization:

- Inpatient
- Subacute
- Residential Treatment
- Detoxification
- Psychiatric Partial Hospitalization Program (PHP)
- Psychiatric Intensive Outpatient Program (IOP)
- Crisis Stabilization (Notification Only)
- Psychological/Neuropsychological Testing
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analysis (ABA) Services
- Comprehensive Child and Family Treatment (CCFT)
- Continuous Treatment Team (CTT)

Authorization requests for urgent inpatient behavioral health services need to be submitted within twenty-four (24) hours of admission or the next business day.

Authorization requests for elective inpatient behavioral health services like residential treatment and any outpatient service requiring prior authorization should be submitted twenty-four (24) hours prior to admission, but no later than one (1) business day after admission.

H. Contact Us

Member Service	Phone	1-888-325-8386
Provider Service	Phone	1-800-924-7141

Prior Authorization for Medical and Behavioral Health	Phone	1-800-924-7141
	Fax	1-800-292-5311
Case Management	Phone	1-888-416-3025
Nurse Advice Line	Phone	1-800-262-2873
TennCare Connect	Phone	1-855-259-0701
Renaissance	Phone	1-866-864-2526

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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, and must be agreed upon by Provider Audit. 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. BlueCare Tennessee audits require establishing a contact within the Provider's office who we can work with to coordinate the audit process, including confirming the records request was received. Failure to respond to our request and/or provide this information could result in a referral to the Division of TennCare Office of Program Integrity.

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 or a referral to the Division of TennCare Office of Program Integrity for failure to cooperate with the audit process.

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, as well as Medical Necessity.

Analysis is performed to identify the need for additional front end edits. While it is possible to implement a new edit to reduce overpayments going forward, Provider Audit will continue to identify and recover overpayments retrospectively. The effective date of a new front end edit is only to communicate to

Providers they will begin to see such claims edits if submitted inappropriately. This notice does not preclude retrospective audit findings for dates of service prior to the edit effective date, or claims that bypass editing for other reasons.

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 is 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. Auditors will begin onsite audits at the scheduled start time. Medical records not provided at the audit start date may result in retraction of payment or a referral to the Division of TennCare Office of Program Integrity for failure to cooperate with the audit process.

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.

Providers that utilize a vendor or provide records through our SFTP site are responsible for ensuring that the records are provided for audit timely.

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 and any approved diagnostic tests, treatments and surgical procedures performed as part of the hospital stay when our recovery audit vendor or Provider Audit has determined that the inpatient admission was not medically necessary or didn't meet contractual terms. BlueCare Tennessee will process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it is the result of an 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. 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 when overpayments are identified.

The overpayment adjustments may take place simultaneously with a facility audit, as well as periodically when identified. BlueCare Tennessee and any of its affiliates and/or subsidiaries reserve the right to periodically evaluate and modify these edits.

D. 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.B. Provider Dispute Resolution Process in this Manual for detailed information.

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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 3.5 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.

7. **Follow-up for elevated blood levels** in children must be carried out in accordance with CDC recommendations. https://www.cdc.gov/nceh/lead/prevention/blood-lead-levels.htm

   Children with elevated blood lead levels should be followed according to CDC guidelines. 2021 CDC guidelines https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm include follow up blood tests and investigations to determine the source of lead, when indicated for blood lead levels equal to or greater than 3.5 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 will provide notification to the Tennessee Department of Health (TDH). The TDH may conduct an investigation to determine the source of lead exposure. 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. 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 2.7.7.3.2, "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 TennCare*Select* 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 TennCare*Select* 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:

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Developmental/Behavioral Screening Tools and Documentation Guidelines – Revised March 2018

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 6-8 weeks postnatal					
Name of Screen	**Age Range for Screen**	**Description**	**Scoring**	**Accuracy**	**Time Frame**
Edinburg Postnatal Depression Scale (EPDS) JL Cox, JM Holden, R Sagovsky, from British Journal of Psychiatry, June 1987, Vol. 150. User may reproduce the scale without further permission providing they respect the copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies. https://www.tnaap.org/programs/behip/behip-overview	6 – 8 Weeks postnatal	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.	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.	Source article indicates that with mothers, who scored above threshold, 92.3% were likely to be suffering from a depressive illness of varying severity.	Less than five minutes

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.					
Name of Screen	**Age Range for Screen**	**Description**	**Scoring**	**Accuracy**	**Time Frame**
Ages & Stages (ASQ) (Formerly Infant Monitoring System) Paul H. Brooks, Publishers, P.O. Box 10624, Baltimore, MD, 21285. (1-800-638-3775); www.brookespublishing.com (Purchase options are available]	0-60 months	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.	Single pass/fail score	Sensitivity ranges from 70% to 90% at all ages except the 4-month level. Specificity ranges from 76% to 91%.	Scoring takes about 7 minutes; questionnaire can be completed in 10-20 minutes.
Brigance Screens. Billerica, MA: Curriculum Associates, Inc. (1985), 153 Rangeway Road, N. Billerica, MA 01862 (1-800-225-0248)	21 to 90 months	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.	Cutoff and age equivalent scores		10 minutes (direct testing only)
Child Development Inventories (formerly Minnesota Child Development Inventories (1992). Child Development Review, Behavior Science Systems, Inc. Box 19512 Minneapolis, MN 55419-9998, 612-850-8700, Fax 360-351-1374 https://childdevelopmentreview.com/ heidi@childdevelopmentreview.com	Birth to 72 months	60 yes/no descriptions with separate forms for 0-18 months. ***Infant Development Inventory (IDI)*** 18-36 months; ***Early Child Development Inventory (ECDI***) and 3 years to Kindergarten, ***Preschool Development Inventory (PDI)*** 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.	A single cut-off tied to 1.5 Standard Deviations below the mean	Sensitivity was 75% or greater across studies and specificity was 70%	About 10 minutes (if interview needed)

Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
Child Development Review Child Development Review, Behavior Science Systems, Minneapolis, MN 55419-9998, 612-850-8700, Fax 360-351-1374 https://childdevelopmentreview.com/ heidi@childdevelopmentreview.com	18 months to kindergarten	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.	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.	Sensitivity 68% or greater. Specificity 88%	5 minutes (if interview needed)
Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandermeer Press, Ltd., P.O. Box 68164, Nashville, TN 37206 Phone: 615-226-4460 Fax: 615-227-0411 http://www.pedstest.com	Birth to 9 years	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.	Categorizes patients into those needing referrals, screening, counseling, reassurance, extra monitoring	Sensitivity ranged from 74% to 79% and Specificity ranged from 70% to 80%.	About 2 minutes (if interview needed)

Autism & Pervasive Development 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.					
Modified Checklist for Autism in Toddlers (M-CHAT). DL. Robins, D. Fein, ML Baron and JA Green. Modified Checklist for Autism in Toddlers (M-CHAT). Journal of Autism and Developmental Disorders. https://www.tnaap.org/programs/start/modified-checklist-for-autism-in-toddlers	18 months of age	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.	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.	Authors indicate that research is pending on sensitivity and specificity	About five minutes
Behavioral/Emotional **4 through 20 years of age**					
Name of Screen	**Age Range for Screen**	**Description**	**Scoring**	**Accuracy**	**Time Frame**
Eyberg Child Behavior Inventory (ECBI) <https://www.parinc.com/Products/Pkey/97	2 ½ to 11 year (best used to age 4) Note: PEDS can also be used to screen possible behavioral problems up to age 9	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. See description above under "General Development"	Single refer/non-refer score for externalizing problems (e.g., conduct, attention, aggression)	Sensitivity 80%; Specificity 86%	About 7 minutes
PEDS	Note: The PEDS can also be used to screen possible behavioral problems up to age 9	See description above under General Development			

Name of Screen	Age Range for Screen	Description	Scoring	Accuracy	Time Frame
Pediatric Symptom Checklist (PSC) Jellinek MS, Murphy, JM, Robinson, J et al. Pediatric Symptom Checklist: Screening school age children for psychosocial dysfunction. Journal of Pediatrics, 1998: 112-201-209 https://www.tnaap.org/resources/developmental-behavioral-health-screening-tools	6 to 18; with modification of items (see article, can be adapted for ages 4 & 5)	35 short statements of problem behaviors to which parents respond with ""never"" "sometimes", or "often". The PSC screens for academic and emotional/behavioral difficulties.	Single refer/non-refer score	Sensitivity ranged from 80% to 95%. Specificity in all but one study was 70% to 100%.	About 7 minutes (if interview needed)
PSC-17 Gardner W, *et. al*. The PSC-17: A brief symptom checklist psychosocial problem subscales: A report from PROS and ADSPN. *Ambulatory Child Health, 1999: 5:225-236.* https://www.tnaap.org/resources/developmental-behavioral-health-screening-tools	4-18	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).	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.	Good sensitivities (.77 - .87) and specificities (.68 - .80) at the optimal cutoff points were reported in the Gardner et. al study.	Less than 7 minutes

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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 3.5 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:

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Recommended Actions Based on Blood Lead Level

Please view recommended actions at: Recommended Actions Based on Blood Lead Level | Childhood Lead Poisoning Prevention | CDC

Recommended Schedule for Obtaining a Confirmatory Venous Sample

BLOOD LEAD LEVEL (µg/dL)	TIME TO CONFIRMATION TESTING
≥3.5–9	Within 3 months*
10–19	Within 1 month*
20–44	Within 2 weeks*
≥45	Within 48 hours*

*The higher the BLL on the initial screening capillary test, the more urgent the need for confirmatory testing using a venous sample.

Schedule for Follow-up Blood Lead Testing

VENOUS BLOOD LEAD LEVELS (µg/dL)	EARLY FOLLOW UP TESTING (2-4 tests after identification)	LATER FOLLOW UP TESTING AFTER BLL DECLINING
≥3.5–9	3 months*	6–9 months
10–19	1–3 months*	3–6 months
20–44	2 weeks–1 month	1–3 months
≥45	As soon as possible	As soon as possible

*Seasonal variation of BLLs exists and may be more apparent in colder climate areas. Greater exposure in the summer months may necessitate more frequent follow ups.

*Some case managers or healthcare providers may choose to repeat blood lead tests on all new patients within a month to ensure that their BLL level is not rising more quickly than anticipated.

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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 is committed to the coordination of school-based, Medically Necessary covered 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 covered services to TennCare-enrolled school age children. For any Medically Necessary non-behavioral health covered service provided in the school setting, TennCare continues to require that there is an Individual Education Plan (IEP), Individual Health Plan (IHP), Individual Family Service Plan (IFSP) or Individualized Service Plan (ISP) including that service and that a parental consent form and an order from the child's treating provider has been obtained. BCT has decided not to require schools to send eligible students' IEPs, IHPs, IFSPs or ISPs to BCT prior to BCT being responsible to pay for the covered, Medically Necessary services. Rather, BCT has decided to audit IEPs, IHPs, IFSPs and ISPs, as it does with other services, which means that each school must prepare and maintain updated IEPs, IHPs, IFSPs or ISPs for each eligible student and then provide any requested IEP, IHP, IFSP or ISP, to BCT upon request. At a minimum, BCT will be required to conduct regular post payment sample audits of IEPs, IHPs, IFSPs and ISPs 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, IHP, IFSP or ISP, the Provider must also include a copy of the appropriate parental consent and the order from the child's treating provider. TennCare has updated the authorization forms, which can be found at https://www.tn.gov/tenncare/tenncare-kids/school-based-services.html.

Additionally, the school district can coordinate with BCT to arrange for services to be provided during school or outside of a school setting. Nothing in this manual is intended to override the requirement that school-based services be determined by the student's support team and provided in the student's least restrictive environment.

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, IHPs, IFSPs and ISPs 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, IHP, IFSP or ISP
- Services must be performed by a participating Provider
- BlueCare Tennessee will conduct post payment audits on a sample of IEPs, IHPs, IFSPs and ISPs for Members who receive Medically Necessary school-based therapy
- If requested, the school must send copies of the IEP, IHP, IFSP or ISP the parental consent and the order from the child's treating provider in support of the services
- Services must be ordered by the eligible student's Primary Care or other treating provider

Members under the age of 21 years are identified as needing to receive physical, speech, or occupational health services in an educational or out-of-school setting through the IEP, IHP, IFSP and ISP process. BlueCare Tennessee covers Medically Necessary Covered Services in the school when the service is documented in the current IEP, IHP, IFSP or ISP, performed by the appropriate Practitioner and parental consent has been obtained. The references above to IEPs, IHPs, IFSPs and ISPs are not applicable to behavioral health services.

Note: It is no longer required to include Medically Necessary covered behavioral health services in the Member's IEP, IHP, IFSP or ISP in school-based settings. Behavioral health services must be performed by a participating Provider and meet guidelines for Medical Necessary services.

School Based Nursing Services

Effective July 1, 2021, certain school-based nursing services ("Nursing Services") provided to eligible students are billable to BCT. Nursing Services are limited to one billable encounter per day, which includes all

services provided that day. Nursing Services must be billed on a CMS-1500 claim form by a participating BlueCare provider, using CPT Code 99211, POS 03. All Nursing Services must be included in the eligible student's IEP and will be audited by BCT, as set forth above.

The Division of TennCare has updated these guidelines to include the following key changes:

- Medically necessary, covered school nursing services listed in the guidelines shall be billable when included in the IEP, IHP, IFSP or ISP
- Three additional billable school-based nursing services (i.e., assessment and treatment of acute and chronic illnesses, blood glucose monitoring and testing, and medication administration for medically fragile students) shall be reimbursable when determined medically necessary and included in student's IEP, IHP, IFSP or ISP
- School-based services rendered to CoverKids members are reimbursable TennCare services,
- Local educational agencies must get a referral or order to provide or bill us for services in a child's IEP, IHP, IFSP or ISP
- Orders for audiology or physical, speech or occupational therapy may come from the child's primary care provider (PCP), audiologist, physical therapist, occupational therapist or speech-language pathologist. Referrals for all other covered, medically necessary services must come from the child's PCP.

TennCare updated its school-based nursing services guidelines (see table below) to include non-oral medication administration* for medically fragile students** as identified in an IEP, IHP, IFSP or ISP as reimbursable services, and to exclude from reimbursement the administration of oral medication (by tablet, capsule, thin films, syrups, or solutions).

The Individualized Education Program (IEP) is the document developed by the school for a school child enrolled in public school who is eligible for special education. This document is created by a multidisciplinary team that includes, but is not limited to, the parent, special education teacher(s), the child's general education teacher(s), a representative of the Local Education Agency (LEA), and other individuals with knowledge of the services and school system (e.g., the child's Primary Care Provider (PCP) when appropriate). This planning is done at least annually or more frequently if needed.

The IEP documents the annual plan of supports and services necessary to meet the educational needs of a child with disability to ensure they receive a free and appropriate public education (FAPE). This includes a statement of the child's present levels of academic achievement and functional performance, measurable annual goals, a description of how the child's progress will be measured toward the annual goals, the special education and related services, and other supplementary aids and supports necessary to advance appropriately toward attaining the annual goals and to be involved in and make progress in the general education curriculum. In addition to the educational components, the plan may include any medical or behavioral supports that are needed for the provision of FAPE. Once the IEP is reviewed and agreed upon and parental consent to bill TennCare is obtained, the plan is implemented. Medically necessary skilled therapy services, behavioral services, and specific nursing services may be covered services and eligible for reimbursement by the child's TennCare Medicaid, CoverKids, or TennCareSelect plan.

An Individualized Service Plan (ISP) is a health care plan, comparable to public school's IEP document, for students that are parentally placed in private school or home school who are identified with one or more educational disabilities that require special services. Parents and other health care providers involved with the child participate in the development and approval of the plan.

The Individualized Family Service Plan (IFSP) is a health care plan for infants and toddlers eligible under Part C of the Individuals with Disabilities Education Act (IDEA). The IFSP must include information about the child's status, the family, results/outcomes, the services needed to help the child and family achieve the outcomes, and other services as needed. The services must indicate the length, duration, frequency, intensity, and method of delivery. There must be a service coordinator associated with an IFSP as well.

An Individual Health Plan (IHP) is a health care plan developed by a registered nurse for children with acute or chronic health issues. Parents and other health care providers involved with the child participate in the development and approval of the plan. The IHP should be developed using the five sequential steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation.

In accordance with State Board of Education Rules 0520-01-13-.01(3)(b), the IHP shall include:

1. Emergency care procedures;
2. A nursing assessment;
3. Physician's orders; and
4. Parental authorization

This manual describes the guidelines for obtaining TennCare Medicaid reimbursement for medically necessary covered school nursing services as required by the IEP and as allowable by TennCare through the Individual Health Plan (IHP), Individualized Service Plan (ISP) and Individualized Family Service Plan (IFSP):

1. The billable services below are performed by the school nurse and shall be ordered by and billed under the NPI of the primary care provider (PCP) or the child's treating provider.
2. The school nurse will meet the clinical and licensing requirements as required by the Tennessee Health Facilities Commission, as well as the training required to perform these services in the school setting.
3. The school will maintain policies and procedures for provision and documentation of the below services listed in the table below.
4. The following are the guidelines for billing:
    a. Use 99211 with POS03 as the daily billable CPT code, to include a global fee.
        i. School nursing services eligible for reimbursement as denoted by (Y) in the table below are restricted to medically necessary covered services included in the IEP, IHP, IFSP or ISP, as applicable.
        ii. Medically necessary, covered services in the IEP, IHP, IFSP or ISP that are ordered by the PCP or treating provider may be reimbursed. The IEP, IHP, IFSP or ISP alone does not satisfy requirements for Medicaid reimbursement. Services are performed by the school nurse, according to the orders of an in-network Physician, Physician's Assistant, or Nurse Practitioner licensed through the Tennessee Health Facilities Commission (HFC). Services are performed pursuant to the student's primary care provider's (PCP) or the child's treating provider's order.
        iii. The Physician, Physician's Assistant, or Nurse Practitioner shall serve as the rendering provider on the claim, as the school nurse is not credentialed and cannot contract with the MCOs as a network provider.
        iv. Administrative services are not billable services.
    b. The billable items in the table below include the code to be used for the services.
    c. TennCare MCOs will contract with any school district(s) that seek(s) to contract with the MCOs, based on the MCOs' standard reimbursement rates, to receive reimbursement for medically necessary, covered services in the IEP, IHP, IFSP or ISP that are ordered by the PCP or treating provider and provided in a school setting.
    d. The MCOs will monitor claims and will retrospectively audit claims for appropriate claims billing and the presence of a valid Provider order to ensure school-based providers are submitting claims appropriately.

If Billable, use corresponding CPT Code: 99211, POS 03. Note: This code is a global encounter code, billable once per day and includes ALL services received.

Service	Billable (Y) / Non-Billable (N)
Assessment and Treatment of acute and chronic illnesses	Y
Blood glucose monitoring and testing	Y
Catheterization	Y
Colostomy care	Y
G-Tube feeding	Y
Nebulizer treatment	Y
O2 saturation monitoring (pulmonary and/or cardiac disease)	Y
Tracheostomy care and suctioning	Y
Wound care	Y
Non-oral medication administration* for medically fragile students** as identified in IEP, IFSP, IHP or ISP	Y
Administration of oral medication - tablet, capsule, thin film, syrup, or solution	N
Development, implementation of Individualized Health Plan (IHP)	N
Development, implementation of Individualized Service Plan (ISP)	N
Development, implementation of Individualized Family Service Plan (IFSP)	N
Evaluation of Nursing service in the Individualized Education Plan (IEP)	N
Postural drainage	N
Vital sign monitoring	N

Restricted to medication that is not administered orally that is either (a) time sensitive where the medication cannot be administered in the home before arriving at school; or (b) pro re nata (PRN) where the medication is required as the circumstance arises such as flare ups of asthma, addressing sudden changes in blood sugar levels, etc.

**TennCare defines “medically fragile” students as children with special health care needs with a serious illness or condition documented by a licensed health care provider that may become unstable and change abruptly, resulting in a life-threatening situation. The medically fragile child requires frequent time-consuming administration of specialized care or treatment which is medically necessary. The care needs may be related to a chronic and/or progressive illness or a more acute, time-limited condition. Some medically fragile children/youth may also have behavioral and/or mental health conditions.

Timely Filing Guidelines for IEP, IHP, IFSP and ISP Services

In July 2021, the Division of TennCare extended timely filing to 365 calendar days from the date of service for all medically necessary, covered IEP services. Beginning July 1, 2022, this standard shall also apply to all medically necessary, covered school district nursing services included in IHP. Effective with dates of services beginning September 1, 2025, this standard also applies to all medically necessary, covered IFSP and ISP services. These timely filing guidelines apply to BlueCare, TennCare*Select* and CoverKids members.

School Districts must submit claims with place of Service 03 and any required documentation within 365 days of the date of service. Any claims submitted outside of the 365-day timeframe, will be denied for timely filing. Corrected bills must be submitted within sixty (60) days from the date of denial or three hundred and sixty five (365) days from the date of service, whichever is later.

Parent Consent/Notice of Access Forms

Effective with dates of service beginning July 1, 2022, the Division of TennCare updated the parent consent form that the students’ parent or legal guardian is required to sign to allow Local Education Agencies (LEAs) to bill TennCare for medically necessary, covered school-based services. Based on the updates, the signed consent form will be valid for as long as the student is receiving IEP, IHP, IFSP or ISP services or until the

parent revokes consent. Therefore, BlueCare will no longer require a new signed consent form at least annually or whenever the IEP, IHP, IFSP or ISP is updated. Additionally, the TennCare Kids Notice of Access form has been updated. Both updated forms shall apply to IEP, IHP, IFSP and ISP services. Spanish and Arabic versions of these forms are also available. These forms can be found on our BlueCare Tennessee Provider website: https://bluecare.bcbst.com/providers/forms/.

For more information on reimbursement for school-based services and billing guidelines, you can view the most current version of the TennCare School-Based Services Billing Manual here:

tn.gov/tenncare/tenncare-kids/school-based-services.html

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.

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 TennCare Kids Provider Trainings twice per calendar year*, some of which are in partnership with TNAAP. These training opportunities include:

- Information on submitting appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TennCare Kids services.
- Education on submitting claims with appropriate codes and modifiers, as described in standardized billing requirements (e.g., CPT, HCPCS, etc.).
- Training on submitting appropriate coding and billing procedures for developmental screenings and adjust billing methodology of procedure codes/modifiers.

*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:

CPT® Code	Network	
	BlueCare	TennCare*Select*
99212 Acute Visit	$29.55	$28.25

99382 EPSDT Code	$91.61	$85.86
Combined Codes	$121.16	$114.11

- **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. Verida 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	1-855-735-4660
TennCare*Select*	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 TennCare Kids Provider Trainings twice per calendar year.

These training opportunities include several elements to include:

- Information on submitting appropriate diagnosis codes identified by TENNCARE in conjunction with evaluation and management procedure codes for TennCare Kids services
- Education on submitting claims with appropriate codes and modifiers, as described in standardized billing requirements (e.g., CPT, HCPCS, etc.)
- Training on submitting appropriate coding and billing procedures for developmental screenings and adjust billing methodology of procedure codes/modifiers

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.

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XXI. BEST PRACTICE NETWORK (BPN) PROVIDER MANUAL

A TennCare*Select* Sub-Network / (Does Not Apply to CoverKids)

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F. General Information

A. Introduction

The Best Practice Network (BPN) is a sub-network of TennCare*Select*, 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 TennCare*Select*. 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 TennCare*Select*. Throughout this Manual, *Select*Kids will be used to denote this Member population.

B. How to Identify *Select*Kids Members

1. Immediate Eligibility for Children in State Custody

TennCare*Select* 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. TennCare*Select* 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 TennCare*Select* for a specified period of time and then are disenrolled from TennCare*Select*.

2. Initial Enrollment of *Select*Kids Member

Until a final determination can be made on a child's TennCare eligibility, TennCare*Select* 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 TennCare*Select* plastic ID card.

When the Division of TennCare approves the child for permanent eligibility, BlueCare Tennessee will issue a permanent TennCare*Select* 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 *Select*Kids Member will receive a plastic TennCare*Select* ID card reflecting the TennCare*Select* logo. Primary Care Provider's (PCP's) name, effective date, and any applicable copayment amount. In order to identify the *Select*Kids Member, the ID card will reflect "*Select*Kids" 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.

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A sample copy of the TennCare*Select* *Select*Kids Member ID Card follows:

Customer Service inquiries for *Select*Kids Members should be directed to:

Provider Services		
(Provider and Family Services Worker)	Telephone	1-800-451-9147
	Fax	1-800-330-2842
Utilization Management	Telephone	1-800-711-4104
(Notification/Prior Authorization)	Fax	1-800-292-5311
Member Services	Telephone	1-888-422-2963
	Fax	1-800-330-2482

3. 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*, 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 and www.bcbst.com.

4. *Select*Kids Member Transition (out of state custody)

*Select*Kids 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* *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 *Select*Kids 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 *Select*Kids 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 "*Select*Kids" identifier and the PCP is no longer responsible for the additional roles and responsibilities required when caring for a *Select*Kids Member. In addition, the enhanced care management fee would no longer apply.

C. BPN Provider Roles and Responsibilities

The Best Practice Network is composed of Primary Care Providers (PCPs) who have agreed to provide appropriate care for *Select*Kids Members who are more difficult to serve because of their health care needs, their mobility, and/or their geographic location.

1. BPN Primary Care Provider (BPN PCP)

BPN PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of *Select*Kids Members. In return for the additional efforts in caring for *Select*Kids Members, BPN PCPs receive a higher reimbursement rate for initial TennCare Kids services and a monthly care management fee.

A. 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.

B. 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.

C. 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.

D. Referrals for Specialty Care

BPN PCPs should utilize the TennCare*Select* Network for specialty, facility, and ancillary medical care.

E. Coordination of Care

Coordination of care is an integral process that ensures continuity of care for *Select*Kids Members. When services are rendered to a *Select*Kids 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.

F. 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.

G. 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 *Select*Kids Members assigned to him/her. *Select*Kids 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 *Select*Kids 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."

H. 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, Tools and Resources | Providers | BlueCare Tennessee

I. 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 Visit Codes:			
New Patient		**Established Patient**	
99381	under 1 year	99391	under 1 year
99382	1-4 years	99392	1-4 years
99383	5-11 years	99393	5-11 years
99384	12-17 years	99394	12-17 years
99385	18-39 years	99395	18-39 years
Developmental Screening Code			
96110 and 96127			

In addition to the preventive visit codes, the Division of TennCare has approved CPT® code 96110 for administration of standardized, validated developmental screening questionnaires, e.g., *Parents' Evaluation of Developmental Status (PEDS); Child Development Inventories*.

CPT® code 96110 will be reimbursed separately from any preventive visit code listed above.

CPT® code 96127 can be billed for brief emotion/behavioral assessment, e.g. *Pediatric Symptom Checklist (PSC)* and will be reimbursed separately from any preventive visit code listed above.

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.

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

New Patient	**Established Patient**
99201	99211
99202	99212
99203	99213
99204	99214
99205	99215

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.

J. TennCare Kids Billing Guidelines

Physicians participating in the BPN are required to complete Model of Care (MOC) training annually. The MOC training is updated annually, and offered via provider self-study and attestation through the BlueCare Learning Management System (LMS). Providers are encouraged to take the training at initial contracting and annually thereafter at the beginning of each calendar year.

- The Provider Model of Care training includes the following:
- Overview of the *Select*Kids Population
- Detailed description of the care management program and information on how to assist members in accessing services
- Detailed description of how the Interdisciplinary Care Team (ICT) functions, ICP development for each member, and expectations that providers will participate in both activities
- Education, resources, and contacts for serving the population
- Providers receive communication about the Model of Care training requirements as well as training reminders via various avenues:

- The BlueCare website
- The Provider Administration Manual
- The BlueAlert, a monthly provider newsletter
- Workshops

The user-friendly MOC computer-based training is provided through the BlueCare LMS via email invite. The LMS is available to providers 24/7 in order for providers to review the material at their convenience and to promote self-service technology, as well as offering an electronic attestation. Reports can be generated regularly to identify physicians in compliance with the Model of Care training. BlueCare monitors these reports and provides additional provider communications as necessary.

2. 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 *Select*Kids Member is seen by a Dentist, a copy of the medical record encounter must be sent to the *Select*Kids Member's PCP. Providers may call DentaQuest toll-free at 1-800-294-9650 for help in locating a DentaQuest participating dentist. **NOTE:** Effective November 1, 2025, Renaissance will be the new Dental Benefits Provider, the **Renaissance Customer Service** phone number will be **1-866-864-2526**.

(See Section XXI, V. B-C. for medical record instructions and sample copies of the medical record update and release of information forms.)

3. Behavioral Health Provider

Referrals to Behavioral Health Providers should be made whenever the *Select*Kids 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 *Select*Kids 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.)

Anytime a *Select*Kids Member is seen by a Behavioral Health Provider, a copy of the medical record encounter must be sent to the *Select*Kids 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.)

4. 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.)

5. Clinical Health Records

In an effort to enhance coordination of care for children in state custody who are enrolled in the TennCare*Select* program (*Select*Kids), 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 *Select*Kids Member, e-mail the Member's name, ID number, and date of birth to SelectKids_GM@bcbst.com.

D. Department of Children's Services (DCS)

1. 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.

2. 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 *Select*Kids Unit at 1-800-451-9147.

E. Confidentiality, Informed Consent and Medical Records

Best Practice Network Providers face several issues concerning confidentiality, sharing of records and informed consent when treating *Select*Kids 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.

1. Confidentiality and Informed Consent

A. 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.

B. 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:

- 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.
- A Practitioner may diagnose, examine, and treat a minor without knowledge or consent of the legal guardian for purposes of providing prenatal care.
- Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian.
- 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.
- 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.

2. Medical Records

A. The following individuals may request and receive copies of the child's medical records:

- 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.
- For mental health records, a juvenile 16 years of age or older.
- A court having jurisdiction over the child.
- 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.

B. 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.

C. 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.

D. 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.

E. 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.

3. 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 *Select*Kids Member's medical records, please call the *Select*Kids 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.

F. General Information

*Select*Kids 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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For information about:	See section:
➢ Where to direct appeals ➢ Contact Telephone Numbers	I. Introduction
➢ Member Eligibility/Liability ➢ Presumptive Eligibility (Breast/Cervical Cancer Group) ➢ Use of Automated Information Line ➢ e-Health Services®	II. How to Identify a BlueCare Tennessee Member
➢ Care Management Fee ➢ Care Management Fee Payment Process ➢ Membership Listings ➢ Primary Care Provider Changes ➢ Member/Provider Relationship Termination	III. Primary Care Member Assignment
➢ Benefits/Covered Services ➢ Benefit Exclusions	IV. Benefits
➢ How to File a Claim ➢ Timely Filing Guidelines ➢ Dual Eligible Members ➢ Third Party Liability (TPL) ➢ Corrected Bills ➢ General Billing Information ➢ Dental Services ➢ Vision Services ➢ Emergency/Non-emergency Transportation ➢ Pharmacy Benefits Manager (PBM) ➢ Provider Overpayments	V. Billing and Reimbursement
➢ PCP Responsibilities ➢ PCP Access and Availability	VI. Primary Care Provider (PCP)
➢ Member Rights and Responsibilities ➢ Member Access-to-Care ➢ Member Appeal ➢ Health Information Library	VII. Member Policy
➢ Medical Review Requirement ➢ Prior Authorization, Retrospective/Focused Retrospective Review ➢ Air Ambulance Transport Services ➢ Emergency Services ➢ Investigational Services ➢ Health Department Services ➢ Medical Necessity Policy	VIII. Utilization Management Program
➢ Prenatal Standards ➢ High-Risk Pregnancies ➢ Women, Infants and Children (WIC) Program ➢ Presumptive Eligibility	IX. OB Services

For information about (cont'd):	See section (cont'd):
➢ Components ➢ Care Management Referral Criteria ➢ Care Coordination Team/Process ➢ Catastrophic Medical Case Management Team/Process ➢ Transplants ➢ Ancillary Care Management/Disease Management	X. Population Health Management
➢ Conflict of Interest ➢ Confidentiality ➢ Quality of Care Studies ➢ Medical Record Keeping Practices	XI. Quality Improvement Program
➢ UM Provider Appeals ➢ Administrative Inquiry ➢ Provider Dispute Resolution Process ➢ Medical Management Program Corrective Action Plan ➢ TennCare Provider Agreement Requirements	XII. Highlights of Provider Agreement
➢ Sterilization, Hysterectomy, Abortions ➢ Associated Anesthesia Services	XIII. Sterilization, Hysterectomy, Abortion Procedures
➢ Preventive Care Guidelines ➢ Preventive Care Services Billing Requirements ➢ Periodic Health Assessment Guidelines	XIV. Preventive Care
➢ Behavioral Health Services	XV. Behavioral Health Care Services
➢ Network Participation Criteria ➢ Provider Identification Number Process ➢ Provider Rights and Responsibilities	XVI. Provider Networks
➢ Credential Applications ➢ Credential Policies ➢ Practice Site/Medical Record Standards	XVII. Credentialing Process
➢ Information on the State of Tennessee's CoverKids Plan	XVIII. CoverKids
➢ Provider Audit Guidelines	XIX. Provider Audit Guidelines
➢ TennCare Kids guidelines and billing instructions	XX. TennCare Kids
➢ Non-Emergency Medical Transportation Services	Attachment I

XXII. Long-Term Services and Supports (LTSS)

(Does Not Apply to CoverKids)

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A. 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.

B. 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 facility;
- 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 Tennessee 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 care 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 or as of October 1, 2022 meet institutional financial eligibility 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 Care Coordinator meets with the member and anyone the Member chooses to be present during the intake visit. The visit includes a review of the Member Handbook and assessment of the Member's needs. The Care Coordinator answers questions related to the CHOICES program and the Member's care, in collaboration with the Member, Member's caregiver, and the Care Coordinator
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 their 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 Tennessee CHOICES Member ID card

Front

Back

Sample copy of TennCare*Select* CHOICES Member ID card

C. Benefits

1. Covered Services

CHOICES Members receive the same benefits as all other BlueCare Tennessee 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-Centered Support Plan (PCSP).

Service and Benefit Limit	Group 1	Group 2	Group 3
Nursing facility care	X	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential alternatives include:			
➢ Assisted Care Living Facility		X	X
➢ Critical Adult Care Homes		X	-
➢ Community Living Supports		X	X
➢ Community Living Supports Family Model		X	X
➢ Companion Care		X	-
Personal care visits (up to 2580 hours per calendar year)		X	X
Home-delivered meals (up to 1 meal per day)		X	X
Personal Emergency Response Systems (PERS)		X	X
Adult day care (up to 2080 hours per calendar year)		X	X
In-home respite care (up to 216 hours per calendar year)		X	X
In-patient respite care (up to 9 days per calendar year)		X	X
Assistive technology (up to $900 per calendar year)		X	X
Enabling technology (up to $5,000 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 9 units per calendar year)		X	X
Employment services/supports as specified below (subject to limitations specified in the approved 1115 waiver and in TennCare Rule)			
➢ Exploration - Individualized Integrated Employment		X	X
➢ Exploration – Self-Employment		X	X

Service and Benefit Limit	Group 1	Group 2	Group 3
➢ Benefits counseling		X	X
➢ Discovery - Individual		X	X
➢ Situational observation and assessment		X	X
➢ Job development plan or self-employment plan		X	X
➢ Job development start-up or self-employment start up		X	X
➢ Job coaching for individualized, wage employment job coaching for individualized, self-employment		X	X
➢ Co-worker supports		X	X
➢ Career advancement		X	X
➢ Integrated Employment Path Services		X	X
Community Transportation		X	X

2. 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 https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20260126.pdf (TennCare Medicaid) or https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-14.20260126.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.

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.)*

3. Consumer Direction

Each CHOICES Member that is assessed to need specified types of HCBS including community transportation, 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 their 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. Examples of self-directed health care tasks are administration of medications and other health care tasks that are Medically Necessary. Prior to beginning self-direction of health care tasks with a Consumer Directed worker, Members are required to review with their PCPs this service method and seek guidance.

D. Care Coordination

1. 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, non-medical risks 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's plan of care (POC) 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 POC and additional needs assessments as necessary.

CHOICES Group 1

For Members in CHOICES Group 1, the Member's Care Coordinator may:

- rely on the Nursing Facility (POC) developed for service delivery instead of developing a PCSP for the Member, if the Care Coordinator agrees the nursing facility POC meets the Member's needs; or
- supplement the Nursing Facility POC 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
- ensure that approved specialized services are part of the Nursing Facility POC developed for the Member and will coordinate with the facility to ensure the services are delivered. Specialized services are to be provided to the member in the community when possible.

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 care) related services and supports, along with signed copies of all documents required in order to allow access to records or decision-making authority by the authorized representative(s), if applicable.
- 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 enabling technology used or needed by the Member (if applicable);
- Description of primary language spoken by the member and/or their primary caregiver, 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;
- A person-centered statement of SMART goals, objectives and desired health, functional, and quality of life outcomes for the Member and how services are intended to help Member achieve these goals;
- Description of other services that will be provided to the Member that address non-medical risk factors, including, but not limited to:
    - 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.

- Relevant 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;
- Relevant 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;
- Frequency of planned Care Coordinator contacts needed, including considerations of the member's individualized needs and circumstances.
- For CHOICES members, if the member chooses to self-direct any health care tasks, the type of tasks that will be self-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;
- The Member's TennCare eligibility end date; and
- An attachment listing all of the member's current LTSS providers, updated when there is a change in LTSS provider.

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 a copy of the PCSP and is now required to acknowledge receipt by signing a separate acknowledgement page. This signature is an agreement to provide the services as outlined and that other confirmations are not allowed as a substitute.

If a member receives services in a provider-owned or controlled setting and if the member has or needs modifications, the new HCBS Settings Modification Informed Consent Form will be required. The new form will replace previous documentation regarding the member's modifications that were captured on the PCSP. The new form will only be shared with the provider implementing the modifications.

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 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 assessment in the PCSP to note this issue, the associated risks and the measures to mitigate the risks. The PCSP 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, Member's PCP, and the Member's community-based 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.

2. 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 services and supports 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. Enabling Technology – as determined by TennCare
5. 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 with 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 MCO 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 regarding each of the rights outlined in the rule.

Effective July 1, 2018, there was no longer a distinct Level 1 and Level 2 Nursing Facility rate in the CHOICES program. Under the new reimbursement system, each NF has 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. This TennCare Rule 1200-13-02 is available at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-02.20221004.pdf.

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.

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:

Tier	Ventilator Weaning	Chronic Ventilator Care	Sub-Acute Tracheal Suctioning	Secretion Management Tracheal Suctioning
High	Established by TennCare	Established by TennCare	Established by TennCare	Established by TennCare
Medium	Established by TennCare	Established by TennCare	Established by TennCare	Established by TennCare
Low	Established by TennCare	Established by TennCare	Established by TennCare	Established by TennCare

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. 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.

   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:

   a. Ventilator care;
   b. Administration of medical gases;
   c. Administration of aerosol medications; and
   d. Diagnostic testing and monitoring of life support systems.

2. 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.

3. 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.
4. 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.
5. 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.
6. Ventilator equipment (and ideally physiologic monitoring equipment) shall be connected to back-up generator power via clearly marked wall outlets.
7. Ventilators shall be equipped with adequate back-up provisions, including:

    a. Internal and/or external battery back-up systems to provide a minimum of eight (8) hours of power;
    b. Sufficient emergency oxygen delivery devices (i.e., compressed gas or battery-operated concentrators);
    c. At least one (1) battery-operated suction device available per every eight (8) residents on mechanical ventilator or with a tracheostomy; and
    d. A minimum of one (1) patient-ready back-up ventilator which shall be available in the facility at all times.

8. 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).
9. 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.
10. 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:

    a. Clinical Assessment of each resident receiving Secretion Management Tracheal Suctioning (including Pulse Oximetry measurements);
    b. Evaluation of appropriate humidification;
    c. Tracheostomy site and neck skin assessment;
    d. Care plan updates; and
    e. Ongoing education and training on patient assessment, equipment and treatment.

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:
    a. Continuous pulse oximetry monitoring; and
    b. 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:
    a. Sufficient emergency oxygen delivery devices (i.e. compressed gas or battery operated concentrators); and
    b. 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 MCO 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
    - Ongoing education and training on patient assessment, equipment and treatment.

    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:
        a. Invasive tracheal suctioning, at a minimum, once every three (3) hours with documented assessment pre- and post-suctioning; or
        b. 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.

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 Tennessee 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:

- The 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.
- 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.

3. 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 Disability and Aging (DDA) 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 (IDEA) 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.

E. Provider Roles and Responsibilities

1. 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;
- 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).

2. 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 Group 1 review Plan of Care (POC), Groups 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 POC or PCSP;
3. develop an emergency and disaster plan with the Member and appropriate caregivers. The 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 plan and verify 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. 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.

*Care Coordination may be reached after normal business hours by contacting the nurse line.

3. 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 planning process driven by the Member;
- Collaboration with the Care Coordinator to help ensure the plan is implemented timely and convenient for the Member;
- Support member with Person-Centered SMART goals as documented in the PCSP for CHOICES members;
- 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, registries, and exclusion checks on its employees, subcontractors, and agents, prior to providing services, in accordance with state law and TennCare policy;
- Investigating and reporting Reportable Events; and
- Providing current financial solvency when providing Community Living Supports services.

F. 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.

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 services including any home health and private duty nursing service, 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.

Electronic Visit Verification (EVV) Hybrid Open Model System – In the EVV Hybrid Open Model, the providers will have a choice to implement their own EVV vendor or utilize the MCO's chosen vendor for EVV. If a provider chooses a separate system apart from the MCO, it will ensure the EVV system is 21st Century Cures Act compliant. The Open Model require HCBS providers (excluding Home Delivered Meals) implementing their own EVV system or vendor to establish business processes and procedures which shall include a standard process by which providers may notify BlueCare of exceptions for which an action by the BlueCare is required for resolution and shall maintain an adequate number of qualified, trained staff to support the operation of the EVV system. All providers must ensure staff has ongoing training and have back-up staff to support EVV systems.

Employment – requires that all staff employed by contracted providers and delivering employment services to CHOICES[2] or ECF CHOICES members obtain certification and training pursuant to TENNCARE guidance and as required for compliance in these programs.

Enabling Technology (ET) – is defined as equipment and/or methodologies that, alone or in combination with associated technologies, provide the means to support individuals' increased independence in their homes, communities, and/or workplaces.

Enabling Technology Vendor or Provider – are contracted network providers with the ability to support the approved person-centered support plan (PCSP) with applicable technology equipment and/or services. Providers must participate in member and MCO planning and scheduled in-person/virtual technology demonstrations as identified during the planning sessions and as applicable.

Hands on HCBS Providers (Including CHOICES CLS and CLS-FM) – Providers of hands on HCBS are required to meet all specified requirements within executed provider agreements, and shall agree to carry adequate liability and other appropriate forms of insurance.

Health Starts Initiative – Describes programming and initiatives intended to address social risk factors through the utilization of screening for social risk factors, referring to community-based organization, and closing the loop on referrals.

Home and Community-Based Services (HCBS) – Services that are provided pursuant to CHOICES, ECF CHOICES, or Katie Beckett programs 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 HCBS, ECF CHOICES, and Katie Beckett are eligible for Consumer Direction. CHOICES HCBS and ECF CHOICES 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 Settings – integrated in and support access to the greater community and provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and offer control of personal resources. It also offers the same access as others that do not receive Medicaid benefits.

Katie Beckett Part A Member – A TennCare Enrollee who has been enrolled by TennCare into Part A of the Katie Beckett Program.

Katie Beckett Part A Program – One of two components of Tennessee's Katie Beckett Program that services a limited number of children with the most significant disabilities or complex medical needs who meet institutional level of care, as established by TennCare, and who qualify for Medicaid only by waiving the deeming of parents income and/or assets to the child.

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/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 TennCare*Select* Agreement.

2 Only through March 31, 2025; unless approved by the Tennessee General Assembly.

Minor Home Modification – Providers should refer to their provider agreements for specific requirements for these services.

Money Follows the Person Rebalancing Demonstration (MFP) – A federal grant that will assist Tennessee in transitioning Eligible Individuals form 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.

PASRR – Preadmission Screening and Resident Review.

PERS – Providers should refer to their provider agreements for specific requirements for these services.

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 – An individual-directed process that may include a representative whom the individual has freely chosen, and others chosen by the individual to contribute to the process. This is a positive approach to the planning and coordination of the services and supports based on individual aspirations, needs, preferences, and values in a manner that reflects individual preferences and goals. The goal of person-centered planning is to create a plan that optimizes the person's self-defined quality of life, choice, control, and self-determination through meaningful exploration and discovery of unique preferences, needs and wants in areas including, but not limited to, health and well-being, relationships, safety, communication, residence, technology, community, resources, and assistance. The person must be empowered to make informed choices that lead to the development, implementation, and maintenance of a flexible service plan for paid and unpaid services and supports in the most integrated setting that reflects personal preferences and choices.

Pest Control – Providers should refer to their provider agreements for specific requirements for these services.

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 Tennessee by the Provider indicating acceptance to provide services in 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).

Religious and Ethical Directives – For a Provider Agreement that includes Ethical and Religious Directives, or when a provider has conscience and religious beliefs that prevents them from providing certain TennCare covered services due to those beliefs include the following requirements:

The provider shall provide a list of the services it does not deliver due to the Ethical and Religious Directives or its conscience and religious beliefs to the CONTRACTOR. The list shall be provided by the Provider to the MCO prior to the start date of the provider agreement with the BlueCare Tennessee and thereafter at least sixty (60) days before implementing any policy to discontinue a covered service based on the Provider's conscience and religious beliefs and/or its Ethical and Religious The Directives BlueCare Tennessee shall furnish this list to TENNCARE pursuant to Section 2.28.3.1 notating those services that are TennCare covered services. This list shall be used by the CONTRACTOR and TENNCARE to provide information to the TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives or its conscience and religious beliefs.

Self-Direction of Health Care Tasks- A decision by a CHOICES or ECF CHOICES member to either direct and supervise a person paid to deliver CHOICES or ECF CHOICES HCBS, or through a contracted provider agency that has been authorized to provide home care services, in the performance of 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 or ECF CHOICES member may elect to have performed as part of the delivery of eligible CHOICES or CHOICES HCBS the member is authorized to receive.

SMART Goals - As it pertains to person-centered planning, a mnemonic or acronym which provides a framework to develop and articulate person-centered goals in which the goals are specific, measurable, attainable, relevant, and time bound.

Social Needs – Basic resources, such as food, safe housing, or transportation.

Social Risk Factors – Conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of individual and population health, functioning, and quality of life outcomes and risks. Social risk factors include socioeconomic status, education, neighborhood, and physical environment (e.g., Housing), employment, social support networks and access to health care. These social and structural factors are key drivers of health care utilization and disparities in health status.

Technology Providers (Enabling and Assistive) – Providers should refer to their provider agreements for specific requirements for these services.

TennCare*Select* Agreement – The Agreement between the State and BlueCare Tennessee whereby BlueCare Tennessee administers the State's TennCare health plan, TennCare*Select*.

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.

BlueCare Tennessee shall maintain all provider agreements in accordance with the provisions specified in 42 CFR 438.12, 438.214 and Section A.2.12 of this Contract. This shall include the Contractor's responsibility to terminate any providers of services or persons terminated [as described in section 1902(kk)(8) of the Social Security Act] under Title XIX, Title XVIII, or Title XXI from participating as a provider in any network.

BlueCare Tennessee shall ensure that Providers who are participants in a TennCare program are not subjected to discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law.

Pursuant to Amendment 22 (CHOICES) to the Contractor Risk Agreement (TennCare*Select*) effective March 1, 2010, and Contractor Risk Agreement (BlueCare Tennessee) 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. The consequences of not completing the PASRR prior to admission to a Medicaid-certified nursing facility are substantial. Federal rules (42 CFR 483.122(b); see also Chapter 1200-13-01-. 10(2)(i), (2)(l), and (3)(e) expressly limit Medicaid funding for nursing facility services to those services provided **after** the PASRR screening and related review are complete. The State's rules go further, noting "Medicaid-certified nursing facilities may not admit individuals applying for admission unless persons are screened (under PASRR)." (Chapter 1200-13-01-.23(2). Because nursing facilities face substantial recoupments and other sanctions if a required PASRR is not completed prior to admission, nursing facilities are unable and unwilling to admit individuals unless and until a required PASRR evaluation is fully complete. An appropriate PASRR is one that is:

    - Negative (without a subsequent determination that PASRR should be positive);
    - Positive with a determination that NF placement is appropriate (if short term, will be end dated to reflect);
    - If short term approval is given, the PASRR determination will have an end date;
    - Positive with a determination that a dementia diagnosis overrides the MI or ID diagnosis;

      or
    - Positive with an appropriate exemption requested and accepted.

    TN PASRR resource page is:

    https://maximusclinicalservices.com/svcs/tn/pasrr/resources

12. Provider shall cooperate with BlueCare Tennessee in developing and implementing protocols as part of the MCO's nursing facility diversion and transition plans (A.2.9.7.7) 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.
13. Prohibit CHOICES or ECF CHOICES providers from altering in any manner official CHOICES, ECF CHOICES or MFP materials unless the CONTRACTOR 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. 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.

15. 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 Disability and Aging (DDA), or the Tennessee Department of Mental Health and Substance Abuse Services as well as any deficiencies cited during the federal certification process.
16. If Provider is involuntarily decertified by the Tennessee Department of Health, Department of Human Services, Department of Disability and Aging, 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.
17. Provider is not required to have liability insurance in excess of TennCare requirements in effect prior to the implementation of CHOICES.
18. 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.
19. 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.
20. Provider shall 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.

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. Providers must obtain written approval from the MCO for a subcontract that is for the purposes of providing TennCare covered services pursuant to your provider agreement with the MCO. The word "subcontract" here has its usual legal meaning. Failure by the provider to obtain by the MCO written approval may lead to the contract being declared null and void by the MCO. Claims submitted by the subcontractor or by the provider for services furnished by the unapproved subcontractor are 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 overpayment, under an executed Provider Agreement.

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 sixty (60) 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. Prior to discontinuing service to the Member or prior to Provider termination of its Provider Agreement, as applicable, the Provider shall be required to:

    a. Provide a written notification of the planned service discontinuation to the Member, their conservator or guardian, and their care coordinator, no less than sixty (60) days prior to the proposed date of service or Provider Agreement termination. Obtain BlueCare Tennessee's approval, in the form of a signed PCSP, to discontinue the service and cooperate with transition to any subsequent, authorized service Provider as is necessary; and consult and cooperate with BlueCare Tennessee in the preparation of a discharge plan for all Members receiving care and service from the Provider in the event of a proposed termination of service. Also, when appropriate, as part of the discharge plan, the terminating Provider shall meet, consult and cooperate with any new Providers to ensure continuity of care and as smooth a transition as possible.
    b. Contracted Providers in CHOICES and ECF CHOICES are responsible for acquiring, developing, and deploying a sufficiently staffed and qualified workforce to capably deliver services to Members in a person-centered way. Upon acceptance of an authorization for services, contracted Providers shall be obligated to deliver services in accordance with the PCSP, including the amount, frequency, intensity, and duration of services specified in the PCSP, and shall be responsible for arranging back-

up staff to address instances when other scheduled staff are not able to deliver services as scheduled. The Provider shall, in any and all circumstances, except Member refusal of continuation of services, instances where the Member's health and welfare would be otherwise at risk by remaining with the current Provider, if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm, or following termination of the Agreement, continue to provide services that maintain continuity of care to the person supported in accordance with their PCSP until other services are arranged and provided that are of acceptable and appropriate quality. BlueCare Tennessee shall document clearly any Member refusal of services, and all concerns and actions taken to remediate the concerns if the welfare and safety of either the Member and/or the worker will result in services not being delivered.

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 their 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 , or they will use a third party EVV vendor. The provider will ensure the EVV system operates in compliance with contractual requirement and in compliance with the 21st Century Cures Act.
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. Providers will be responsible for building schedules timely and in accordance with members' preference in the EVV systems.
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 Reportable Events 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 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.2.12.8, A.2.12.9, 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.2.12.9.44 regarding hospital protocols; Section A.2.12.9.45 regarding reimbursement of obstetric care; Section A.2.12.9.58.2 regarding prior authorization of pharmacy; and Section A.2.12.9.59 regarding coordination

with the Pharmacy Benefits Manager (PBM). Exceptions may also be granted to these and other requirements in Section A.2.12 for certain ECF CHOICES HCBS as specified by TENNCARE in writing.

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.

    a. Provider is not allowed to solicit potential and/or actual BlueCare Tennessee and TennCare*Select* Members to choose them as their CHOICES Provider.
    b. 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.

16. Discriminatory Requirements - The provider shall be interacting with individuals from diverse cultural backgrounds including, individuals with LEP, individuals with low literacy, individuals with disabilities, including individuals with vision, cognitive, hearing, and speech disabilities, therefore, the provider shall have policies and procedures for delivering services in a nondiscriminatory and cultural competent manner, providing free language and communication assistance services to individuals, providing individuals with reasonable accommodations, discrimination complaint procedures, and for regularly inspecting assessment methods and any data algorithms, such as clinical algorithms, to promote equal outcomes and eliminate bias with generating assessment results. The provider’s staff members carrying out the terms of the provider agreement shall receive annual training on the provider entity’s: policies on how to deliver services in a nondiscriminatory and culturally competent manner, complaint procedures, process to obtain free language assistance services for LEP individuals, process for providing free effective communication services (auxiliary aids or services) to individuals with disabilities, and process for providing reasonable accommodations for individuals with disabilities. The provider entity’s new hires carrying out the terms of the provider agreement shall receive this training within thirty (30) days of joining the entity’s workforce.
17. The provider shall provide any discrimination complaint or request for a reasonable accommodation received relating to TennCare’s services and activities within two (2) days of receipt to TennCare’s Office of Civil Rights Compliance (“OCRC”) at HCFA.Fairtreatment@tn.gov. The provider agrees to cooperate with OCRC and other federal and state authorities during discrimination complaint investigations and reviews for requests for reasonable accommodations and to assist individuals in obtaining information on how they can report a complaint or request a reasonable accommodation that involves TennCare’s services or activities by contacting OCRC. To satisfy this obligation the provider may direct the individual to OCRC’s webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, to call TennCare Connect at 855-259-0701, or to the member’s MCO if the member needs assistance with filing a complaint or requesting a reasonable accommodation.
18. As required by 42 CFR 438.206, Providers and Subcontractors that are providing services pursuant to this Contract 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 sex. This includes the CONTRACTOR ensuring that network providers have the capabilities to ensure physical access, reasonable accommodations, and accessible equipment for the furnishing of services to enrollees with physical or mental disabilities.

If the provider is an ICF/IID 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 ICF/IID Provider (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 request for admission to the ICF/IID or when there is a change in a 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 not admit any person to an ICF/IID for whom Medicaid reimbursement will be sought prior to completion of a Community Informed Choice process as prescribed by TENNCARE, and approval of such admission by the State;
3. Provider to provide written notice to TENNCARE and BlueCare Tennessee in accordance with state and federal requirements before voluntarily terminating the agreement and to comply with all applicable state and federal requirements regarding voluntary termination;
4. Provider shall notify BlueCare Tennessee prior to beginning to develop an involuntary discharge plan and shall consult with BlueCare Tennessee's IDD team to intervene in resolving issues if possible and, if not, to prepare and implement a discharge and/or transition plan as appropriate, including reasonable time to prepare the member and their parents or guardian for discharge or transfer;
5. Provider shall notify the member and/or the member's representative (if applicable) in writing prior to discharge in accordance with state and federal requirements, including involving the member and their family or legal guardian in planning for any transfer or discharge. This process must include providing a summary of the member's course of stay in the ICF/IID, a final summary of the member's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the member's IPP as well as a post-discharge plan of care;
6. 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;
7. Provider's responsibilities and prohibited activities regarding patient liability (see Sections A.2.6.7 and A.2.21.5 of this CRA), include but are not limited to collecting the applicable patient liability amounts from members residing in an ICF/IID, notifying BlueCare Tennessee if there is an issue with collecting a member's patient liability, and making good faith efforts to collect payment;
8. Provider shall conduct timely certification and recertification (as applicable) of the member's level of care eligibility for ICF/IID services and level of need for and receipt of continuous active treatment, and cooperate fully with BlueCare Tennessee in the completion and submission of the level of care assessment;
9. Provider shall submit complete and accurate PAEs that satisfy all technical requirements specified by TENNCARE, and accurately reflect the member's current medical and functional status. Provider shall also submit all supporting documentation required in the PAE and required pursuant to TennCare rules;
10. 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 and level of need for and receipt of continuous active treatment;
11. Provider shall establish and implement an approved utilization review plan in accordance with state and federal regulations. The plan must be written, provide for a review of the necessity to stay at least every six (6) months or more frequently if indicated at the time of assessment, submitted to BlueCare Tennessee for review and approval, and monitored by BlueCare Tennessee on an ongoing basis to ensure that it is implemented and that utilization of ICF/IID services continues to be appropriate for each of BlueCare Tennessee 's members served in the facility;
12. Provider shall provide individualized health and related services as well as active treatment services as prescribed in federal regulation and in accordance with each member's individual program plan, and to coordinate with BlueCare Tennessee as needed to facilitate timely access to medically necessary services beyond the scope of the ICF/IID benefit;
13. Provider shall comply with state and federal laws and regulations applicable to ICFs/IID as well as any applicable federal court orders, including but not limited to the American with Disabilities Act and those that govern admission, transfer, and discharge policies;
14. Provider shall cooperate with BlueCare Tennessee in developing and implementing protocols as part of BlueCare Tennessee 's ICF/IID diversion and transition plans pursuant to the Americans with Disabilities Act, which shall, include, at a minimum, the ICF/IID's obligation to promptly notify BlueCare Tennessee upon request for admission of an eligible member regardless of payor source for the ICF/IID stay; refusal of admission of any person to an ICF/IID for whom

15. Medicaid reimbursement will be sought pending completion of a Community Informed Choice process as prescribed by TENNCARE, and approval of such admission by the State; how the ICF/IID will assist BlueCare Tennessee in identifying current ICF/IID residents who may want to transition from ICF/IID services to home and community-based care; the ICF/IID's obligation to promptly notify BlueCare Tennessee regarding all such identified members; and how the ICF/IID will work with BlueCare Tennessee in assessing the member's transition potential and needs, and in developing and implementing a transition plan, pursuant to 42 C.F.R. 483.440;
16. Provider shall have on file a 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;
17. Provider shall immediately notify BlueCare Tennessee of any change in its license to operate as issued by DDA as well as any deficiencies cited during the federal certification or licensure process;
18. If Provider is decertified (i.e., it's participation in the Medicaid program is terminated by the Tennessee Department of Health or the Centers for Medicare and Medicaid Services) BlueCare Tennessee's provider agreement with such ICF/IID will automatically be terminated; and
19. The provider agreement shall be assignable from BlueCare Tennessee to the State, or its designee, at the State's discretion upon written notice to BlueCare Tennessee and the affected ICF/IID provider. Provider shall be bound by any such assignment, and that the State, or its designee, shall not be responsible for past obligations of BlueCare Tennessee.

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 DDA-compliant home study and a current DDA 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 Event Management Coordinator who shall be trained on Reportable Event processes by the CONTRACTOR as prescribed by TENNCARE. Such staff member shall be the Provider's lead for Reportable Events, be primarily responsible for tracking and analyzing Reportable Events pursuant to Section A.2.12.15.4 and be the CONTRACTOR's main point of contact at the Provider agency for Reportable Events.
- 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 preventions 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 receives 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.
- CHOICES and ECF CHOICES 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 dollars ($1,000,000.00).
    - A provider's Comprehensive Commercial General Liability coverage must include an automobile coverage add-on to the policy to cover transportation as a component of service delivery within LTSS programs. Providers are no longer required to have a stand-alone policy to automobile coverage.

Enabling Technology Providers/Vendors

Providers approved to participate in the CHOICES provider network as an Enabling Technology provider must meet all credentialing requirements and have an executed contract with appropriate licensure, including all background check, registry, and exclusion checks requirements for agency and applicable staff.

For providers who support members utilizing Enabling Technology:

Required as directed by TennCare and DDA*. Monitored through credentialing/QA/*DDA*. Provider requirements, including requirements for reporting and investigations, are outlined in the One Reportable Event Management System (REM) Protocol.*

- Training on the member's Person-Centered Support Plan (PCSP);
- Behavior Support Plan (BSP);
- Identified risks and risk mitigation;
- Additional Reportable Event Management training, staffing plans, and
- All other relevant plans and considerations prior to working with the member.

Enabling Technology providers must adhere to all guidelines as outlined in the protocol. Details below.

DIVISION OF TENNCARE LONG TERM SERVICES AND SUPPORTS OPERATIONAL PROTOCOL

PROTOCOL TITLE: Enabling Technology Utilization Protocol: Screening Tool, Service Requests, and Implementation Requirements for CHOICES, Employment and Community First CHOICES and 1915(c) Waiver Members
EFFECTIVE DATE: 11/2/2021

Direct Service Worker Oversight and Monitoring

Contracted Providers must conduct ongoing supervision and monitoring of the Provider's Direct Service Workers who provide home-based services to ensure that services are consistently provided in accordance with the Member's PCSP and with best practices, quality, and program requirements and standards. Monitoring of each worker shall occur in accordance with services provided at random intervals. These visits must include unannounced visits and conversations with Members (and their families, as applicable), regarding the quality of the services provided, as well as any problems or concerns. Provider shall maintain documentation of monitoring visits, including observations and other information gathered, and any actions taken to address problems or concerns and improve the services provided to the Member, which shall be reviewed by BlueCare Tennessee as part of re-credentialing processes.

Unless otherwise noted, all CHOICES direct support staff (i.e., provider staff working directly with people in CHOICES) must complete required pre-service training as prescribed by TENNCARE within thirty (30) days of hire and prior to providing direct support to members.

G. Provider Contracting/Credentialing

Except as prescribed by TennCare, BlueCare Tennessee's CHOICES program for Long-Term Services and Supports (LTSS) has a process for credentialing and re-credentialing long-term services and supports 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 Services (HCBS) Providers, they must be re-credentialed at least annually: Adult Day Care, Assisted Care Living Facility, Home Delivered Meals, Personal Care Services, 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/enabling 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 Tennessee 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 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 Settings 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, registry and exclusion 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), and TennCare Termination list 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 be required to immediately submit a written report to the Contractor any exclusion information discovered. The Provider shall be informed by the Contractor 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. The Provider shall also be required to have an individual assessment policy for assessing potential employees whose criminal background check, registry, or exclusion checks 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;
    - Reportable Events 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;
    - The following link on the Division of TennCare LTSS website, will provide the most current staff training requirements for LTSS Operational Protocol; Training Requirements for ECF CHOICES, CHOICES, and Katie Beckett Providers; LTSS Employment Staff Training Requirements: https://www.tn.gov/tenncare/long-term-services-supports/documents.html
    - Provider agencies are permitted to hire family members or other household members in caregiver roles to perform home and community-based (HCBS) services, as well as certain limited Medicaid services, provided that the individual meets the qualifications and criteria for employment (i.e., licensure/certification, background check qualifications, training requirements, etc.) that would apply to any individual in a paid caregiving role;
    - Provide agencies who hire family members are required to report and track the number of members with a paid family caregiver, along with additional information including the caregiver's relationship to

the member. In addition, the agency will report the total hours the paid family caregiver worked and submit the data to BlueCare Provider Relations by the required due date;

and

8. Has policies and processes in place to ensure:

- Compliance with BlueCare Tennessee's Reportable Events 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 Settings 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, registry or exclusion checks, TennCare Termination List, LEIE checks, training requirements, Reportable Events reporting and management, and use of the EVV.

Personal Care Service Providers must maintain written policies and procedures of their business model. The policies and procedures shall include at a minimum, roles and responsibilities of key personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste and abuse employee training as required by Deficit Reduction Act of 2005 Section 6032. BlueCare Tennessee shall have provisions in its Compliance Plan to perform a coordinated audit of a sampling of Personal Care Service Providers to be submitted annually to TennCare with the Compliance Plan. Upon initial credentialing, and annual recredentialing, thereafter, BlueCare Tennessee shall verify required policies and procedures are implemented. BlueCare Tennessee will confirm through random sampling that Providers who were credentialed/recredentialed from January–May 2020, have met the new business model requirements.

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 Tennessee/TennCare*Select* application
- CHOICES Rep Checklist
- 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 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.

When executed by both parties, the BlueCare Tennessee Provider Agreement shall become effective as of the Effective Date indicated on the Agreement's Signature Page and shall continue in effect unless terminated in accordance with the terms of the Provider Agreement. The Agreement will automatically renew unless the Provider provides, in writing, by August 1 of the current year, the intent to terminate effective January 1 of the following year.

Provider shall conduct ongoing supervision and monitoring of all direct support staff who provide home-based services to ensure that such services are consistently provided in accordance with the Member's PCSP and with best practices, quality, and program requirements and standards. Monitoring of each direct support worker shall occur at least once per calendar month at random intervals and shall include at least quarterly unannounced visits and conversations with Members (and Members' families, as applicable) regarding the quality of the services provided, as well as any problems or concerns. Provider shall maintain documentation of monitoring visits, including observations and other information gathered, and any actions taken to address problems or concerns and improve the services provided to the Member, which shall be reviewed by BlueCare Tennessee as part of its re-credentialing processes.

Note: Quality monitoring of CHOICES services by DDA shall include only CLS and CLS-FM.

All CHOICES and I/DD Programs providers are required to allow DDA staff access to pertinent CHOICES and I/DD Program member documentation in order for DDA to perform its oversight role (applicable in CHOICES for Reportable Event Management and Quality Monitoring for specified services).

All providers for CHOICES and I/DD Programs are required to comply with DDA investigations as prescribed by TennCare protocol.

Credentialing Requirements for CHOICES Providers

Adult Day Care (recredentialed annually)

- License to practice in accordance with 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/Enabling Technology (recredentialed every 3 years)

- License to practice in accordance with 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 with 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 with 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 with 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 with 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 with 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 with 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 with 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 with 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 with 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 Transportation (recredentialed annually)

- License to practice in accordance with 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

Employment Services (recredentialed annually)

- Individual Employment Support
- Exploration – Individualized Integrated Employment
- Exploration – Self-Employment
- Benefits Counseling
- Discovery – Individual
- Situational observation and assessment – individual
- Job development plan or self-employment plan
- Job development start-up or self-employment start-up
- Job Coaching for individual wage employment
- Job Coaching for self-employment
- Co-worker supports
- Career Advancement
- Integrated Employment Path Services
    - License to practice in accordance with 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 sate sanctions (Medicare/Medicaid or TennCare)
    - Attestation to the correctness of the application

HCBS Credentialing (CHOICES Program) - Attachment A

Responsibility	Action
HCBS Providers: Personal care services, personal care, In Home Respite	Personal Support Services Agency (PSSA) or Professional Support Services Facility, Home Health Agency or Nursing Facility PSSA or Home Health Agency
Adult Day Care	Intellectual Disabilities Adult Habilitation Day Facilities/Services license from the Department of Disability and Aging (DDA) or Adult Day Care License from Department of Human Services
Assisted Care Living Facility	Assisted Care Living Facility (ACLF) or Nursing Home Facility
Inpatient Respite	ACLF or Nursing Home Facility
Community Living Supports or Community Living Supports Family Model	Adult Habilitation Day-Semi-Independent Living or Residential Habilitation license from Department of Disability and Aging (DDA)
Assistive Technology/Enabling Technology	DME license or other retail/wholesale supplier business license
Home Delivered Meal	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
Pest Control	TN Dept. of Agriculture (pest control charter)
Personal Emergency Response System	Nursing Home, Hospital or general business license, FCC & UL certifications (if provided)
Minor Home Modifications	Service Agency, Building supplier, contractor, carpenter, craftsman or DME supplier
Adult Care Home	Adult Care Home license from Department of Health
Exploration – Individualized Integrated Employment	This is a one-time, time-limited, and targeted service designed to help an individual make an informed choice about whether s/he wishes to pursue individualized, integrated employment or self-employment.
Exploration – Self-Employment	This is a one-time, time-limited, and targeted service designed to help an individual make an informed choice about whether s/he wishes to pursue individualized, integrated self-employment. Self-Employment Exploration includes but is not limited to: Initial meeting with job coach or job developer to discuss SE goals, collecting information to assist the person in making an informed choice on the pursuit of SE, and feasibility study and consultation with local advisory agencies. This may consist of virtual or in-person meetings with job developer and advisory agencies with the goal of informing the person on SE. At the conclusion of SE Exploration, the individual will choose whether to continue pursuing SE. Additionally, the job developer will work to identify supports needed, discuss fading of paid job supports, and the expectations of job developer and job seeker. Completion and approval of the SE Exploration template is required for completion. Benefits counseling is mandatory during this phase through VR or the waiver
Benefits Counseling	A service designed to inform the individual and their family of the multiple options and pathways to paid, integrated employment and increased economic self-sufficiency, to repudiate myths, and to alleviate fears and concerns that choosing to seek integrated, competitive employment at prevailing wages would jeopardize their benefits. This service is provided by a certified Community Work Incentives Coordinator (CWIC) whether self-employed or an employee of a service provider.

Responsibility	Action
Discovery - Individual	This is a one-time, time-limited and targeted service designed to help an individual, who wishes to pursue individualized, integrated employment or self-employment, to identify through person-centered assessment, planning and exploration.
Situational Observation and assessment	SOA includes observing and assessing an individual's interpersonal skills, work habits and vocational skills. This is done through practical, experiential, community-integrated volunteer experiences and/or paid individualized, integrated work experiences. These experiences are uniquely arranged by the provider and specifically related to the job seeker's interests, preferences, and transferable skills. This allows the provider the ability to observe and assess the individual's actual performance with the core job competencies and duties required of a person in that position. The goal is to further determine the work competencies and skills needed by the individual to be successful in environments like where the experience is taking place. Members can get paid during this experience or they can take place unpaid. SOA can run alongside the following employment services: Benefits Counseling, Discovery, Integrated Employment Path, Job Coaching, Co-Worker Supports, ECF Small Group.
Job Development plan or Self-employment plan	This is a one-time, time-limited and targeted service designed to create a clear plan for Job Development or the start-up phase of Self-Employment. This service is limited to thirty (30) calendar days from the date of service initiation for Job Development Plan and is limited to ninety (90) calendar days from the date of service initiation for Self-Employment Plan. This service includes a planning meeting involving the individual and other key people who will be instrumental in supporting the individual to become employed in competitive or customized employment or to become self-employed
Job Development start-up or Self-employment start-up	Job Development Start-Up is support to obtain a competitive or customized job in an integrated employment setting in the general workforce, for which an individual is compensated at or above the minimum wage, but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Self-Employment Start-Up is support in implementing a self-employment business plan.
Job Coaching for individualized integrated employment or self-employment	Job coaching includes identifying and providing services and supports that assist the individual in maintaining and advancing in individualized employment in an integrated setting that pays at least minimum wage but ideally not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For self-employment, includes identification and provision of services and supports that assist the individual in maintaining self-employment through the operation of a business and is not time limited. This service is designed to help a member maintain competitive, integrated employment in the community and may also include supports for people supported engaged in individualized integrated self-employment. Supports may be provided directly or indirectly to the member, his/her supervisor and/or coworkers, but these supports cannot be billed for more hours than the member has worked during the billing period. Supports must be guided by a Job Coaching Fading Plan, which incorporates systemic instruction using task analysis, low-and high-tech assistive technology, and effective engagement of natural supports, as needed. Since fading is expected, multiple levels of reimbursement for job coaching are available to help facilitate the process and may be approved for up to one (1) year in advance. People supported are placed in an acuity tier Based on an objective level of need assessment and fading expectations for that acuity level.

Responsibility	Action
Co-Worker supports	This service involves a provider of Job Coaching for Individualized Integrated Employment entering into an agreement with an individual's employer to reimburse the employer for supports provided by one or more supervisors and/or co-workers, acceptable to the individual, to enable the person to maintain individualized integrated employment with the employer.
Career Advancement	This is a time-limited career planning and advancement support service for persons currently engaged in individualized integrated employment or self-employment who wish to obtain a promotion and/or a second individualized integrated employment or self-employment opportunity. The service is time limited and focuses on developing and successfully implementing a plan for achieving increased income and economic self-sufficiency through promotion to a higher paying position or through a second individualized integrated employment or self-employment opportunity.
Integrated Employment Path Services	The provision of time-limited learning and work experiences, including volunteer work opportunities, where a person can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings
Community Transportation	Community Transportation services are offered in order to enable individuals, and his/her personal assistant as needed, to gain access to employment, community life, activities and resources, that are identified in the ISP. These services allow individuals to engage in typical day-to-day, non-medical activities such as going to and from paid, competitive, integrated employment, the grocery store or bank, participating in social events, clubs and associations and other civic activities, or attending a worship service when public or other community-based transportation services are not available.

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 the following link https://provider.bcbst.com/publicsites/provider/tools-resources/documents-forms.

Change of Ownership (CHOW)

A CHOW occurs when there is a change in ownership, including either a change in individual owners, corporations, or general partnerships (e.g., a new partnership agreement would constitute a CHOW).

Buyers considering a CHOW must notify TennCare and Managed Care Organizations (MCOs) **at least sixty (60) days prior** to the anticipated effective date of the CHOW. Failure to notify the MCOs at least sixty (60) days prior to the effective date of the CHOW may result in claim payment delays.

If there are changes to the proposed CHOW effective date or the transaction is not completed, the buyer must notify TennCare and TennCare MCOs as soon as possible of either the change in the effective date or cancellation of the proposed CHOW. When a Buyer assumes the existing MCO Provider Agreement, all buyers must sign both a participating agreement with the State and a provider agreement with the MCOs to allow participation in the Medicaid program. To expedite the CHOW process, the State requires that MCOs have a provider agreement in place with the buyer – either a newly executed contract or assignment of the previous contract – prior to the effective date of the CHOW. If the buyer assumes the existing MCO provider agreement, the buyer receives benefits such as any underpayments discovered after the CHOW. However, the buyer also assumes all penalties and sanctions under the MCO program, including repayment of any accrued overpayments discovered, regardless of who had ownership of the provider agreement at the time of the overpayment unless fraud was involved. If fraud is involved, in any fiscal year the seller had assignment, responsibility for the repayment of fraudulent overpayments remains with the seller.

If the seller refuses to assign, or the buyer refuses to assume the existing MCO provider agreement, the buyer must enter into its own MCO provider agreement.

Claims Processing

Claims for dates of service by the Provider *on or after* the CHOW **must be filed using the NPI/Medicaid ID for the new owner**.

Claims for dates of service prior to the date of the CHOW will continue to be billed under the seller's NPI.

In the event the provider contract is terminated because of a change of ownership, BlueCare Tennessee shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

H. Billing and Reimbursement.

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 Tennessee/TennCare*Select* 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		
Revenue Code	**Title**	**Description**
0191	Subacute Care - Level 1	Level 1 ICF - Applicable for Short and Long Term Stays
0224	Date of Discharge – Deceased after 12:00 noon	Level 1 ICF – Applicable for Short and Long Term Stays
0192*	Subacute Care – Level 2 **Enhanced**	Chronic Ventilator Care – Billed with CPT® Code 94004.
0192*	Subacute Care – Level 2 **Enhanced**	Vent Weaning –Billed with CPT® Code 94004 and Modifier SC.
0192*	Subacute Care – Level 2 **Enhanced**	Tracheal Suctioning –Billed with CPT® Code 31899.
0192*	Subacute Care – Level 2 **Enhanced**	Tracheal Suctioning Secretion Management - Billed with CPT® Code 31899 and Modifier SC.
0224*	Date of Discharge – **Enhanced** if Deceased after 12:00 noon	Chronic Ventilator Care – Billed with CPT® Code 94004.
0224*	Date of Discharge – **Enhanced** if Deceased after 12:00 noon	Vent Weaning –Billed with CPT® Code 94004 and Modifier SC.
0224*	Date of Discharge – **Enhanced** if Deceased after 12:00 Noon	Tracheal Suctioning –Billed with CPT® Code 31899.
0224*	Date of Discharge – **Enhanced** if Deceased after 12:00 Noon	Tracheal Suctioning Secretion Management - Billed with CPT® Code 31899 and Modifier SC.

*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.

Modifier UD must be added to the CPT Code when the member is receiving dialysis in conjunction with ERC service.

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 I) 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:

Level 2 - HCBS

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
Adult Care Home - Level 2 Day Vent Dependent	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-day basis is living in the home with the individuals for whom they are providing care. Level 2 Per diem	No	T2033	3109	U1	Day
Adult Care Home - Level 2 Day Traumatic Brain Injury	Level 2 Per diem	No	T2033	3109	U2	Day
Adult Care Home - Level 1 Month	Level 1 Per Month	No	T2032	3109	U1	
Adult Care Home - Level 2 Month	Level 2 Per Month	No	T2032	3109	U2	
Adult day care	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.	No	S5100	0570		15 minutes
Assisted Care Living Facility - Day	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.	No	T2031	3109		Day
Assisted Care Living Facility - Month		No	T2030	3109		Month

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
Assistive technology	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.	No	T2029	0590	U4	Unit equals 1 device
Enabling Technology Items/Services	Equipment and/or methodologies that, alone or in combination with associated technologies, provide the means to support individuals' increased independence in their homes, communities, and/or workplaces.	No	A9279	0590		Unit equals 1 item
Companion Care – Back-Up	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 their behalf, pursuant to requirements for representatives otherwise applicable to consumer direction.	Available **ONLY** in Consumer Direction	S5136	0570		1 Unit
Companion Care – Daily	5 Days Per Week/24 Hours Per Day	Available **ONLY** in Consumer Direction	S5136	0570	U1	1 Unit
Companion Care – Daily	7 Days Per Week/24 Hours Per Day	Available **ONLY** in Consumer Direction	S5136	0570	U2	1 Unit
Community Transportation	To be authorized when reimbursing fare for use of public transit, taxi, paying someone for gas, etc. (monthly transportation budget). This code does not mean reimbursement is only made to a Consumer Directed (CD) worker, it means the member is	Yes	T2003	960	UC	1 Unit

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
	consumer directing this budgeted amount.					
Community Transportation – Stand-Alone Transportation Service Provided by Contracted Service Provider	Non-emergency transportation; per diem (for provider agency use only): This is separate and distinct from non-emergency transportation (NEMT) offered under the Medicaid State Plans with their respective vendors.	No	T2002	960		1 Unit
Community Transportation – Standard Ambulatory Unit Rate for Employment	Non-emergency transportation; per diem (for provider agency use only): This is separate and distinct from non-emergency transportation (NEMT) offered under the Medicaid State Plans with their respective vendors.	No	T2002	960	U1	1 Unit
Community Transportation – Standard Ambulatory Unit Rate for Community Activities	Non-emergency transportation; per diem (for provider agency use only): This is separate and distinct from non-emergency transportation (NEMT) offered under the Medicaid State Plans with their respective vendors.	No	T2002	960	U2	1 Unit
Community Transportation – Wheelchair Accessible Unit Rate for Employment	Non-emergency transportation; per diem (for provider agency use only): This is separate and distinct from non-emergency transportation (NEMT) offered under the Medicaid State Plans with their respective vendors.	No	T2002	960	U3	1 Unit
Community Transportation – Wheelchair Accessible Unit Rate for Community Activities	Non-emergency transportation; per diem (for provider agency use only): This is separate and distinct from non-emergency transportation (NEMT) offered under the Medicaid State Plans with their respective vendors.	No	T2002	960	U4	1 Unit
Home-delivered meals – Frozen	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.	No	S5170	0590		Meal
Home-delivered meals – Fresh	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	No	S5170	0590	U1	Meal

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
	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.					
In-home respite care	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.	Yes	S5150	0660		15 minutes
In-patient respite care	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.	No	S5151	0660		Day
Minor home modifications	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	No	S5165	0590		N/A

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
	in accordance with applicable state or local building codes.					
Personal care visits	Visits up to 2580 hours per calendar year 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 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 Care of non-service related pets and animals.	Yes	T1019	0570		15 minutes
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.	No	S5160	0590		1 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

Service	HCPCS Service Description	Available for Consumer Direction	HCPCS Code	Revenue Code	Modifier	Unit
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 located at https://bluecare.bcbst.com/Forms/CHOICES/CHOICES_Claims_Reference_Guide.pdf. 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

I. 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.

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, a written notice will be sent 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 benefit determination 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 ten (10) calendar days; and
- receive a written decision about the outcome of the appeal.

To appeal, a Member must respond within sixty (60) 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 Member Medical Appeals | Appeals Processing 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:	Member Medical Appeals | Appeals Processing Unit	**Fax to:**	1-888-345-5575
	P O Box 00593	**Call:**	1-800-878-3192
	Nashville, TN 37202-0593		

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
Member Medical Appeals | Appeals Processing 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**).

J. Provider Appeal Process

See Section XII. Highlights of Provider/Subcontractor Agreement in this Manual for information on Provider payment disputes and independent reviews.

K. General Information (CHOICES)

1. Background Checks and Registry Checks, and Exclusion Checks

Criminal background checks, exclusion, 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, and exclusion checks must be performed on any person who will have direct contact with a person receiving services in CHOICES. At a minimum, criminal background checks, including registry checks, exclusions 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) and System for Award Management (SAM), and TennCare Terminated Provider List.

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, ECF CHOICES, or Katie Beckett Member. If a potential

employee or volunteer's criminal background check, registry checks, or exclusion checks 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, registry or exclusion checks 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 and exclusions 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.

The FEA is responsible for conducting background checks, registries, and exclusions in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers, or anyone acting for or on behalf of the CONTRACTOR conducts criminal background checks and registry checks, and exclusions in accordance with state law and TennCare policy. At a minimum, registry checks shall include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, Social Security Death Master File, TennCare's Terminated Provider List, System for Award Management (SAM), and List of Excluded Individuals/Entities (LEIE). The FEA shall be responsible for conducting background checks, registries, and exclusions on its staff, its subcontractors, and consumer-directed workers. Criminal background checks and registry checks, and exclusions checks must be performed on any employee or volunteer who will have direct contact with a member in CHOICES or ECF CHOICES. 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 positions or engaging in certain occupations, an individual whose background check, registries or exclusions reveals past criminal conduct shall be given an opportunity to undergo an individualized assessment in accordance with the applicable laws and legal guidance.

2. Reportable Event Management

Reportable Event Management (REM) Requirements

In HCBS programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, BlueCare Tennessee, and DDA, as outlined in the One Reportable Event Management System Protocol.

Providers are to comply with the requirements specified in the TennCare One Reportable Event Management System Protocol and Definitions. Reportable Events must be submitted to the Department of Disability and Aging by the close of the next business day after witness or discovery of the event.

Providers with access to the Preadmission Evaluation and Referrals for Long Term Services and Supports (PERLSS) system are required to submit all Reportable Events through PERLSS.

To submit a Reportable Event within PERLSS:

1. Log in to the PERLSS system.
2. From the PERLSS Dashboard, navigate to the QuILTSS section in the left navigation menu.
3. Select REM Intake.
4. Click Start Reportable Event Form.
5. Follow the instructions to complete and submit the form.

Providers without access to PERLSS may submit Reportable Events using the external submission link: https://perlss.tenncare.tn.gov/externalrem.

Tier 1 Reportable Events must also be reported to DDA's Abuse Hotline (1-888-633-1313) as soon as possible, but no later than four hours after the occurrence of the event or the discovery thereof and shall also be reported to Adult Protective Services (APS), Child Protective Services (CPS) and/or law enforcement, as required by law.

For any Reportable Event, the provider shall have supervisory staff (including clinical staff, as applicable) review the Reportable Event and determine appropriate follow up. For Reportable Behavioral Events, this may include follow up with the member's PCP or behavioral health provider, as applicable, to provide information and determine any needed treatment adjustments, follow up with the person's Care Coordinator, Support Coordinator, Independent Support Coordinator, or DDA Case Manager regarding any needed adjustments in the Person-Centered Support Plan, and targeted training or assistance for agency staff who support the person. All Reportable Events, any medical attention provided and follow up shall be documented in the member's record.

Further information on REM can be found on the TN.gov website at: Reportable Event Management (REM)

3. 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 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.

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.

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 2.15.7.1.4.5. The Provider should coordinate and cooperate with Adult Protective Services/Child Protective Services investigations and remediations.

Adult Protective Services

Phone	1-888-277-8366
Online	https://reportadultabuse.dhs.tn.gov/

Child Protective Services

Phone	1-877-237-0004
Online	https://apps.tn.gov/carat/

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).

4. 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.

5. BlueCare Tennessee EVV Provider Compliance Plan for Open Model

The Division of TennCare will implement a hybrid approach of an Open Electronic Visit Verification (EVV) Model for Personal Care Services Providers within Tennessee. Providers may choose to use the MCO vendor as their EVV solution for their agency, or they may choose to contract with a Third-Party EVV solution. If providers choose a Third-Party EVV solution, they will be responsible for any costs associated with that solution. The MCO vendor will integrate with the agency chosen EVV vendor as the state aggregator.

Providers contracted with BlueCare Tennessee must adhere to the EVV compliance program in accordance with established metrics and required standards. BlueCare Tennessee 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.

Providers must develop and maintain agency policy and procedure to align with the hybrid open model requirements and attend initial and ongoing training. The policies and procedures must include agency protocols for employee attendance specific to call outs that may impact member services. Agencies should include contingency plans to manage and monitor member schedules to oversee missed and late visits to include initiation of back-up plans as the MCO will not monitor visits in real time. Providers are responsible for real time monitoring of member visits.

Providers must create a schedule of services from the service authorizations entered for each member that supports the amount, frequency, duration and scope of each service according to the PCSP. Providers must have the ability to establish schedules that allow flexibility for arrival times when the member desires to have a “window of time” for services.

Additionally, all Providers are required to comply with the 21st Century Cures Act, and any policies conveyed by BlueCare Tennessee to safeguard programs and improve the process of Home Care. Providers must ensure that all employees entered in the EVV data base to support Members must include social security numbers as part of employee personal data. Providers, whether they choose to use a third-party vendor, must ensure that their Worker Social Security Numbers are entered into the EVV system upon each worker’s hire date.

Providers are responsible for timely and accurate submissions of EVV Missed and Late Visit Reports. Reporting must include appropriate reason codes when Members are not supported in accordance to the Person-Centered Support Plan (PCSP) as outlined in the approved authorizations. Providers must have associated mitigating action plans to avoid ongoing non-compliant service. Failure to adhere to any parts of EVV policies or compliance requirements will increase Provider corrective actions and/or liquidated damages.

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 or provided by the provider’s third-party EVV vendor. Providers should validate the accuracy of claims prior to submissions, in accordance to the authorization effective for the date of service on the claim. Providers will be required to maintain paper time sheets when an approved check in and check out device is not available, and agencies will be subject to MCO auditing of these time sheets.

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 data base. Any grace periods required must be approved by BlueCare Tennessee.

Provider EVV Compliance Monitoring

The CONTRACTOR shall submit a monthly CHOICES and ECF CHOICES Provider Compliance Report for CHOICES Members regarding personal care, and for ECF CHOICES Members regarding personal assistance and supportive home care. The report shall contain information on specified measures including but not limited to the following, Provider name and region in which services are provided, and the Provider ID.

BlueCare Tennessee will monitor the compliance of each Provider and report on the following components of their required EVV usage and approved EVV methodology:

- Total number of visits and percentage of visits that were checked in and out via the GPS device;
- Total number of visits and percentage of visits that were checked in and out via the IVR system;
- Total number of visits and percentage of visits that were checked in and out via the worker's personal device:
- Total number of visits and percentages of visits that were checked in and out via manual confirmation process due to system or authorization issues:
- Total number of visits and percentage of visits that were checked in and out via manual confirmation process due to worker or Provider issues. For each of these visits, the report shall include specific and immediate actions taken to address the provider EVV compliance. Actions taken will include Provider's improvement toward meeting and maintaining compliance.

As part of the Provider compliance monitoring, BlueCare Tennessee captures the frequency and usage of the GPS device as the first and preferred method of an individual Provider staff person or worker when clocking in and clocking out when providing services to a member. The arrival and departure is also captured and monitored through the individual Provider staff person or worker's SSN. Monitoring continues and is reported in real time, or at a minimum, within twenty-four (24) hours when a worker has clocked into multiple visits at the same time. The overlapping information is shared among all MCOs when the worker works for multiple agencies and the person supported is not within the same MCO.

When a GPS device is not available, or unable to be turned on, not receiving an internet signal, or if the GPS approved device is broken, Providers are mandated and monitored to report these issues immediately.

Providers are allowed to use as the next approved method of clocking in and clocking out the Bring Your Own Device (BYOD). And lastly, the Interactive Voice Response (IVR).

Manual confirmation is not an electronic form of verification and is NOT COMPLIANT.

Oversight of Provider Compliance

BlueCare Tennessee closely monitors and tracks the volume of manual confirmations, and when Providers are not compliant by meeting and maintaining 90 percent minimum performance on any reporting metrics. The below actions are taken against the non-compliant Provider or agency.

Based on the provider compliance they will be sent letters every 30 days.

- Verbal and written warning/required and mandatory re-training
- Corrective Action Plans
- Suspension of New Referrals
- Termination when the Provider is unable to demonstrate full compliance

Providers receive a monthly Individual Compliance Report indicative of their previous month's performance.

Any questions pertaining to the BlueCare Tennessee Compliance Program should be directed to the CHOICESProviderRelations@bcbst.com email box.

Third-Party EVV Vendor Users

Provider agencies that choose to use a third-party vendor instead of the MCO vendor must ensure they are compliant to the following requirements:

- Name of person receiving the service
- Name of the worker providing the service
- Date of service
- Location of service
- Type of service
- Clock in and clock out of services
- Late and missed visits and reasons

Additionally, the system must be:

- HIPAA compliant
- Able to integrate with the MCO's EVV system which is the aggregator

- Able to receive and store service authorizations for individual members
- Ensure each worker has an acceptable method to clock in/out of visits and store the data in the EVV platform
- Maintain updated member demographic data in the EVV system
- Transmit member service authorizations to EVV vendor and align with record retention standards
- Ensure that the EVV system selected has the ability to capture worker notes
- Notify MCO's immediately of a system outage with the EVV vendor
- Absorb all costs associated with using a third-party vendor, including any device the worker needs to clock in and out.

6. 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 their 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.

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XXIII. *SELECT*COMMUNITY PROGRAM

(Does Not Apply to CoverKids)

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A. Introduction

The Division of TennCare established a TennCare*Select* program called *Select*Community. *Select*Community 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 *Select*Community 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 *Select*Community program at the same time.

All claims for care provided to *Select*Community 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 *Select*Community Members.

All participating TennCare*Select* Providers are eligible to provide services to *Select*Community Members. The *Select*Community Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of *Select*Community Members. *Select*Community 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 *Select*Community Member who is assigned to their practice. No minimum enrollment is required.

B. How to Identify *Select*Community Members

1. Determining Eligibility

The State of Tennessee determines Member eligibility for the *Select*Community Program. Only the State of Tennessee can enroll Members in the *Select*Community Program.

2. Enrollment of *Select*Community 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 *Select*Community Program at any time. To initiate the transition, the Member or a responsible party must call the TennCare Solutions Unit at **1-800-342-3145** to request enrollment in *Select*Community.

3. ID Card

Each *Select*Community 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 *Select*Community-covered.

The *Select*Community 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 *Select*Community Member ID card follows:

Front

Back

For inquiries or to arrange authorizations call:

Provider/Member Services	Telephone	1-800-292-8196
Utilization Management	Telephone	1-800-292-8196

(Notification/Prior Authorization)

4. 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*, *Select*Community 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 "Get Started" in the upper right corner of the home page, next to "Providers", click "Create Account" 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.

C. *Select*Community Provider Roles and Responsibilities

The *Select*Community Network is composed of Primary Care Providers (PCPs) who have agreed to fulfill special roles and responsibilities associated with the management and care of *Select*Community Members. In exchange for the fulfillment of these roles and responsibilities, an enhanced care management fee is paid for each *Select*Community Member who is assigned to their practice. No minimum enrollment is required.

1. 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 *Select*Community 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 *Select*Community Members regardless of who has provided these services.
- Forward medical files to a newly assigned PCP and provide an initial consultation when the *Select*Community Member is transferred to a new PCP.
- Forward pertinent information to providers seeing *Select*Community 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 *Select*Community Members they see.
- Work closely with BlueCare Tennessee's Nurse Care Manager in the coordination of care for *Select*Community 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.

2. Referrals for Specialty Care

*Select*Community PCPs should utilize the TennCare*Select* Network for specialty, facility, and ancillary medical care.

3. Coordination of Care

Coordination of care is an integral process that ensures continuity of care for *Select*Community Members. When services are rendered to a *Select*Community Member, the Provider rendering the service should communicate the information related to the encounter to the *Select*Community PCP either through the *Select*Community *Medical Record Update* form or via letter, which contains the information requested on the form.

4. PCP Care Management Fee

*Select*Community PCPs receive a $10.25 per Member per month Care Management Fee as compensation for their agreement to fulfill the *Select*Community Network PCP Roles and Responsibilities. The *Select*Community Care Management Fee is in lieu of the TennCare*Select* Management Fee, and no minimum enrollment is required.

5. Preventive Care

Every *Select*Community Member should receive checkups, even if there is no apparent health problem. The *Select*Community PCP is expected to provide a "medical home" for the *Select*Community Members assigned to him/her. *Select*Community Members may pose special management issues because they may have incomplete or poorly documented health records, and they may present to the *Select*Community PCP without a reliable medical history.

The *Select*Community PCP may provide preventive services. The following offers guidelines for 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 *Select*Community Member presents to the *Select*Community PCP with an inadequate history and unreliable historian, the *Select*Community 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 Kids in this Manual for details on Interperiodic Screening).

A. 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.
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.
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.

B. 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/quality-initiatives/wellchild.

C. 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.

D. Nurse Care Manager

The Nurse Care Manager is the primary point-of-contact for all Members, caregivers, and Providers.

Each *Select*Community 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 *Select*Community 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.
- 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 Disability and Aging (DDA).
- 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 TennCare*Select* 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 *Select*Community.
- 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. The Nurse Care Manager may substitute video conference for 2 monthly contacts every 90 days.
- 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. The Nurse Care Manager may alternate in-person and video conferencing.

- 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. The Nurse Care Manager may alternate in-person and video conferencing contacts with in-person visit required annually.
- 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 establishes 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.

E. Medical Records

*Select*Community PCPs have agreed to maintain health information on all physical and behavioral health services for assigned *Select*Community Members regardless of who provided the services. The *Select*Community 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 *Select*Community *PCP Medical Record Update* form can be found on the BlueCare website at https://bluecare.bcbst.com/providers/tools-resources/documents-forms.

F. General Information

*Select*Community is an Integrated Care Management Program created within TennCare*Select* for certain persons with Intellectual Disabilities. As such, *Select*Community Member benefits are the same as all other TennCare*Select* 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 TennCare*Select* Program:

For information about:	See section:
➢ Where to direct appeals ➢ Contact Telephone Numbers	I. Introduction
➢ Member Eligibility/Liability ➢ Presumptive Eligibility (Breast/Cervical Cancer Group) ➢ Use of Automated Information Line ➢ e-Health Services®	II. How to Identify a BlueCare Tennessee Member
➢ Care Management Fee ➢ Care Management Fee Payment Process ➢ Membership Listings ➢ Primary Care Provider Changes ➢ Member/Provider Relationship Termination	III. Primary Care Member Assignment

For information about:	See section:
➢ Benefits/Covered Services ➢ Benefit Exclusions	IV. Benefits
➢ How to File a Claim ➢ Timely Filing Guidelines ➢ Dual Eligible Members ➢ Third Party Liability (TPL) ➢ Corrected Bills ➢ General Billing Information ➢ Dental Services ➢ Vision Services ➢ Emergency/Non-emergency Transportation ➢ Pharmacy Benefits Manager (PBM) ➢ Provider Overpayments	V. Billing and Reimbursement
➢ PCP Responsibilities ➢ PCP Access and Availability	VI. Primary Care Provider (PCP)
➢ Member Rights and Responsibilities ➢ Member Access-to-Care ➢ Member Appeal ➢ Health Information Library	VII. Member Policy
➢ Medical Review Requirement ➢ Prior Authorization, Retrospective/Focused Retrospective Review ➢ Air Ambulance Transport Services ➢ Emergency Services ➢ Investigational Services ➢ Health Department Services ➢ Medical Necessity Policy	VIII. Utilization Management Program
➢ Prenatal Standards ➢ High-Risk Pregnancies ➢ Women, Infants and Children (WIC) Program ➢ Presumptive Eligibility	IX. OB Services
➢ Components ➢ Care Management Referral Criteria ➢ Care Coordination Team/Process ➢ Catastrophic Medical Case Management Team/Process ➢ Transplants ➢ Ancillary Care Management/Disease Management	X. Population Health Management
➢ Conflict of Interest ➢ Confidentiality ➢ Quality of Care Studies ➢ Medical Record Keeping Practices	XI. Quality Improvement Program
➢ UM Provider Appeals ➢ Administrative Inquiry ➢ Provider Dispute Resolution Process ➢ Medical Management Program Corrective Action Plan ➢ TennCare Provider Agreement Requirements	XII. Highlights of Provider Agreement
➢ Sterilization, Hysterectomy, Abortions ➢ Associated Anesthesia Services	XIII. Sterilization, Hysterectomy, Abortion Procedures

For information about:	See section:
➢ Preventive Care Guidelines ➢ Preventive Care Services Billing Requirements ➢ Periodic Health Assessment Guidelines	XIV. Preventive Care
➢ Behavioral Health Services	XV. Behavioral Health Care Services
➢ Network Participation Criteria ➢ Provider Identification Number Process ➢ Provider Rights and Responsibilities	XVI. Provider Networks
➢ Credentialing Applications ➢ Credentialing Policies ➢ Practice Site/Medical Record Standards	XVII. Credentialing Process
➢ Information on the State of Tennessee's CoverKids Plan	XVIII. CoverKids
➢ Provider Audit Guidelines	XIX. Provider Audit Guidelines
➢ TennCare Kids resources and helpful tips	XX. TennCare Kids
➢ Non-Emergency Medical Transportation Services	Attachment I
➢ Tennessee Health Care Innovation Initiative Provider Guide	Attachment II
➢ Information on State of Tennessee's CHOICES Plan	XXII. CHOICES
➢ Information on State of Tennessee's ECF CHOICES Plan	XXIII. ECF CHOICES

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XXIV. 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.

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:
   a. correcting a significant congenital malformation or disfigurement caused by disease or injury;
   b. preventing significant malformation or disease; or
   c. 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:
   a. Comfort measures in the absence of disease or injury; or
   b. 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:

1. in accordance with generally accepted standards of medical practice; and
2. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, Physician or other health care Provider; and
4. 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

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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XXV. Attachment I: Non-Emergency Medical Transportation (NEMT) Services

Non-Emergency Medical

Transportation Provider Manual

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Introduction to TENNCARE and the NEMT Program

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 & 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, a Pharmacy Benefits Manager (PBM) for his pharmacy services and dental services, which are provided by a Dental Benefits Manager (DBM). The state added its own MCO, called TennCare*Select*, to serve as a backup if other plans failed or there was inadequate MCO capacity in any area of the state. TennCare*Select* 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 Intellectual Disabilities (ICF/IID), 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 Verida, Inc. to manage all NEMT services for BlueCare/TennCare*Select* members enrolled under their TENNCARE Managed Care Plan.

The Role of the Verida

Verida (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 transportation. Verida 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 Verida include NEMT provider payment functions, compliance and regulatory functions, data analysis, and reporting.

More specifically, Verida has responsibility to:

1. Receive calls requesting NEMT services. The member should contact Verida to request NEMT services at least two business days 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 transport request.
3. Determine that each transport 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 transportation.

4. Determine the availability of suitable transportation and decide how to provide the transport 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 transportation to the most appropriate NEMT provider. Verida 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 transportation for eligible members to covered services as defined by TENNCARE guidelines.
8. Transmit all NEMT providers' upcoming transportation to them via fax or e-mail.
9. Follow up to ensure that the transportation was provided in a safe and timely manner. (This includes the duties related to transportation reconciliation and billing.)
10. Reconcile transportation 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 Verida.
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.

Verida Office Locations and Contact Numbers

Verida's Tennessee Call Center is located at:

Eastgate Town Center
Verida, Inc.
5600 Brainerd Road, Suite H-100
Chattanooga, TN 37411
Office: 423-893-8282
Fax: 423-893-8225

Verida Corporate Office is located at:

843 Dallas Highway
Villa Rica, Georgia 30180
Phone: 678-510-4600
Fax: 404-762-8443

BlueCare Tennessee Contact Numbers

BlueCare Provider Customer Service:	1-800-468-9736
TennCare*Select* Provider Customer Service:	1-800-276-1978

Overview of Verida Staff Functions

The following Verida positions are your points of contact within the Verida organization:

Chief Operations Officer (COO) – Oversees all aspects of the Verida operations including:

- Management of the Verida executive team
- Establishment of corporate policies and procedures
- Liaison between Verida and the Verida Advisory Committees
- Ensuring NEMT provider payments are made timely
- Liaison between Verida and BCT
- Ensuring compliance with contracting agencies

Chief Information Officer (CIO) – Oversees the Information Technology and all communications equipment including:

- Maintaining Verida computer equipment

- Maintaining Verida 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 Verida 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 (Verida 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 transportation 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 Verida 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/TennCare*Select* participating healthcare provider or the service has been approved by BlueCare/TennCare*Select*. If an eligible member request transportation to an out-of-state healthcare provider that is not a participating BlueCare/TennCare*Select* provider, the request must be referred to a BlueCare/TennCare*Select* Customer Service for review and approval.

If a member requests a healthcare provider located outside the access standards, and BlueCare/TennCare*Select* 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/TennCare*Select* to grant the member's request. However, in such cases BlueCare/TennCare*Select* shall not be responsible for providing transportation for the member to access care from this selected provider, and BlueCare/TennCare*Select* 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/TennCare*Select* 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/TennCare*Select* members about the NEMT broker system, announcing Verida as the new broker, including contact information and hours of operation, and other information about using NEMT services.

NEMT Access

Verida provides functions to assure that transportation services are only approved for eligible TENNCARE members who are assigned to BlueCare/TennCare*Select* as their MCO and are requesting transport to TENNCARE covered services. Members should reserve transportation services at two business days prior to the appointment, unless the request qualifies as an urgent care transportation. Urgent care transportation include immediate needs such as hospital discharges and similar circumstances where the transportation could not be scheduled in advance.

To ensure BlueCare/TennCare*Select* members have access to NEMT services, Verida' 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/TennCare*Select* members.

Approval Requirements

All NEMT services must receive approval by Verida before a transportation is considered authorized. Members or healthcare providers must contact Verida' Call Center for transportation approval prior to the delivery of transportation services. Verida' Call Center operates on a 24-hour basis to provide transportation approvals whenever the need occurs.

Verida' standard practice is to inform the member of the transportation arrangements during the phone call requesting the NEMT service. If that is not possible, Verida 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 Verida 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 transportation 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.

Verida issues transportation confirmation numbers to NEMT providers for each approved transportation assigned to the NEMT provider via a transportation manifest. Verida will send transportation manifests to a NEMT provider by a facsimile device or secure electronic transmission (e-mail), at the option of the NEMT provider. Verida will ensure that provision of the transportation 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 transportation assignments are made after a manifest has been issued, Verida must contact the NEMT provider by telephone to confirm that they will accept the transportation and then fax/e-mail the transportation add-on information to the NEMT provider. No payments shall be issued for transportation without valid transportation confirmation numbers issued by Verida.

Verida will also communicate information regarding cancellations to the NEMT provider in an expeditious manner to avoid unnecessary transportation.

Validity of Information

Verida 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.

Transport 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, Verida requires the healthcare provider

requesting the transportation 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.

Verida' 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

Verida 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 Verida 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" transportation. While there may exist a difference in what the member desires as their mode of transportation versus what is appropriate, Verida 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 Transportation

Urgent transportation 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 transportation must meet the same basic requirements as regular appointments except for the two business days advanced scheduling requirement. An urgent transportation can have one (1) or multiple transportation legs. Verida reserves the right to request verification directly from the healthcare provider stating that the need for an urgent transportation, 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. Transportation mileage does not determine if a transportation is urban or rural.

Urgent transportations 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 two business days 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 Verida 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 transportation does not qualify as an urgent transportation based on the above definition, Verida will make reasonable efforts to schedule the member's request with a network NEMT provider, a non-network provider, or a Verida 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 transport that do not meet urgent care criteria less than two business days 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. Verida 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 transportation manifests shall indicate when an escort has been approved for an assigned transportation.

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

Verida 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 Verida 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.

Verida 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. (Verida ***will ask if the escort has legal authority to sign for medical care for foster or stepchildren when scheduling transportation services.*** Verida ***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/TennCare*Select* 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/TennCare*Select* member. Verida 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 Verida that adversely affects their transportation needs or their access to care. All appeal procedures are handled by BlueCare/TennCare*Select* 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/TennCare*Select* Member Services Department listed below based on their MCO plan.

BlueCare Member Services	1-800-468-9698
TennCare*Select* Member Services	1-800-263-5479

If a member requests to file an appeal or refuses to contact BlueCare/TennCare*Select* for further assistance, Verida will refer the member directly to the TENNCARE Solutions Unit to file an appeal.

If BlueCare/TennCare*Select* 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

Verida 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 Verida 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 Verida 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, Verida' Dispatchers are available to respond to urgent transportation requests and other after-hour issues that require immediate attention. Verida' 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 transportation management system to schedule transportation and to process urgent care transportation requests. They also have eligibility verification capabilities and immediate access to the manager on-call for the Verida Tennessee Operations.

After-hours requests to schedule non-urgent transportation will be received and processed by Verida Dispatchers in the Tennessee Call Center or the Dispatcher will record the Member's name and telephone

number and a Verida Customer Service Representative will contact the Member during normal business hours on the following day.

Telephone Numbers:

For Transportation Reservations:

BlueCare Statewide	1-855-735-4660
TennCare*Select* - Statewide	1-866-473-7565
Verida Tennessee Administrative Office:	(423) 893-8282

Transportation Performance Standards

2. Verida 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 Verida expectations. These specific standards are provided to all Transportation providers in the NEMT Provider Agreement which is reviewed and approved by TENNCARE. Verida monitors all Transportation providers to ensure compliance with the required standards.
3. Verida 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, Verida 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 damages, suspension or reduction of transportation assignments or termination of NEMT Provider Agreement.
4. Transportation is 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.
5. 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.
6. In addition to the initial inspections prior to entering into service agreements with NEMT providers and the annual inspections as required by TENNCARE, Verida 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.
7. All transportation services must only be provided by NEMT drivers and vehicles that have been authorized by Verida 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 transportation assignments, and/or termination of NEMT Provider Agreements.

NEMT Provider Responsibilities

Administrative and General Requirements

1. NEMT providers shall receive transportation reservations via fax or e-mail from Verida each day and confirm the receipt thereof in a form acceptable to Verida for ASAP or urgent transportation. NEMT providers shall accept telephone orders from Verida.
2. NEMT providers shall transport members and escorts or accompanying adult as applicable in accordance with the specifications of the reservations provided by Verida 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. Verida will ensure that if a NEMT driver refuses to transport a member the NEMT driver immediately notifies their dispatcher, and the dispatcher notifies Verida. Verida will notify BCT immediately. BCT will ensure members are given notice of appeal rights for any refused transportation.

The NEMT Broker should receive telephone request to pick members up for return transportation from medical facilities, healthcare providers, dental or pharmacy transportation.

3. NEMT provider shall inform Verida of their inability or unwillingness to schedule or complete an assignment with sufficient notice to allow Verida 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 Verida 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.
4. NEMT provider shall establish and maintain both a dedicated telephone line and fax line for the exclusive use by Verida to contact NEMT provider. The fax line shall be equipped with a fax machine.
5. NEMT provider shall ensure that all information obtained regarding BlueCare/TennCare*Select* 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 Verida.

NEMT Providers and Member Confidentiality

Verida 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 Verida.

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.

Verida 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, Verida 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 Verida, 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 Verida, 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 Verida 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 Verida and the NEMT provider to a halt, if for any reason the NEMT provider cannot meet the requirements of this Section, TENNCARE, BCT, and Verida 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 Verida, 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 Verida 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 Verida and the NEMT provider shall be as permitted and/or required under the law;
- Report to Verida, 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 Verida 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 Verida, 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.
- In the event that the request for an accounting of disclosures is submitted directly to Verida, Verida 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;
- 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.

- 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 Verida 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 Verida. 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 Verida or the NEMT provider's system.
- 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 Verida' 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 Verida 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
- 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, Verida and the NEMT provider periodically report in summary fashion such security incidents. Verida 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 Verida are "information holders" as defined in TENNCARE CRA, TSA, and TCA 47-18-2107. In the event of a breach of the security of Verida or the NEMT providers information system, as defined by TCA 47-18-2107, the NEMT provider and/or Verida 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:
  - Make its individually identifiable health information available to members for amendment and access as specified and restricted under the federal HIPAA regulations;
  - Establish policies and procedures for minimum necessary access to individually identifiable health information with its staff regarding MCO administration and oversight;
  - Adopt a mechanism for resolving any issues of non-compliance as required by law; and
  - Establish similar HIPAA data partner agreements with its subcontractors and other business associates.

Pick Up and Delivery Standards

Verida 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 Verida Provider Orientation Training and in the NEMT Provider contracts. Verida 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 Verida 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 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 transportation from an appointment, the NEMT provider will arrive at pre-arranged times for the return leg of the transportation. If there is no pre-arranged time for the return leg of the transportation, the vehicle shall arrive within one (1) hour from the time the Verida 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 Verida of any unreported Standing Order re-routes due to weather, holiday(s) or any other unforeseen event.
- Verida 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 Verida' 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 Verida deems it in the best interest of the member(s), Verida will dispatch another vehicle to expedite the transportation.
- The NEMT provider will monitor transportation 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. Verida will ensure that if a NEMT driver refuses to transport a member the NEMT driver immediately notifies their dispatcher, and the dispatcher notifies Verida.
- 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 Verida of any incident or accidents.

Verida' transportation 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 Transportation Reimbursement Form. Verida' 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 Transportation 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 Verida' transportation management software during the transportation reconciliation and payment approval process.

Verida' Transportation Management software generates reports on all NEMT Providers comparing scheduled and actual transportation times on a daily, weekly, or monthly basis. A Pick-up and Delivery Standards Report will be submitted by the Verida 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 Verida 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.

Verida will conduct a "coach and counsel" meeting with NEMT Providers who have repetitive substandard on-time performance problems. During this remedial training session, Verida 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 transportation, 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, Verida reserves the right to reduce the NEMT Providers number of transportation assignments and reassign transportation 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. Verida 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 Verida must meet the requirements listed below. Each vehicle is subject to an initial and annual inspections by Verida, 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 Verida.

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, ambulances and DDA Vehicles, 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 Verida 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 Verida.
- 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 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/TennCare*Select* members are being transported.
- The vehicle license number, NEMT business phone number, Verida, and Verida' 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 Verida 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 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’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 Verida 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 transportation cannot be completed as scheduled and the NEMT provider should immediately contact Verida.

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 Verida, as well as interim inspections as required by Verida 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 Verida 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 Verida, 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 Verida 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 Verida 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** – Verida 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. Verida' 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. Verida 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/TennCare*Select* members remain unchanged. These requirements were established by the Division of TENNCARE and apply to all transportation services and agencies rendering service to BlueCare/TennCare*Select* 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 five (5) not 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 identification badges on the driver's outerwear in plain sight between the neckline and the waist. These badges are to be provided by the Provider with the driver's picture, first and last name listed, Providers Company name listed, and must be pre-approved by Verida, Inc.
- Drivers shall not engage in any behavior or practices that shall subject TENNCARE, BCT or Verida 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 Verida.
- 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 Verida.

The NEMT provider shall ensure that NEMT drivers immediately notify the NEMT provider and that the NEMT provider immediately notifies Verida if a driver is arrested for, charged with, or convicted of a criminal offense that would disqualify the driver under the agreement with Verida.

Verida 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. Verida reserves the right to require a non-compliant driver to attend a coach and counsel session conducted by Verida 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 Verida 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 Verida, as well as interim inspections as required by TENNCARE, BCT or Verida 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 Verida to charges against protected groups.
- Verida 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 transport 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 Verida deems it necessary Verida may require a driver(s) to be retrained.

Verida shall confirm all employees, agents, subcontractors, providers, drivers, and attendants are subject to criminal background, registry, and exclusion checks in accordance with TennCare policy and Tennessee law.

Any driver or attendant convicted of a criminal offense related to that individual'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) shall be ineligible to perform services under this Agreement.

Any driver or attendant listed on the Tennessee Sexual Offender Registry, or the equivalent registry showing data from all fifty (50) states, shall be ineligible to provide services under this Agreement. Results shall be maintained in each driver's or attendant's file to allow for unscheduled file audits. Verida shall require sexual offender registry checks be completed on all drivers and attendants prior to providing services under this Agreement, and every year thereafter.

Any driver or attendant found guilty of any “disqualifying offense”, as determined by BCT and/or Verida, shall not provide services under this Agreement. Disqualifying offenses include, but are not limited to, permanent and interim disqualifying criminal offenses set forth in 49 C.F.R. § 1572.103. Prior to providing services, and every five (5) years thereafter, each driver and attendant shall obtain and submit to Verida a national/state criminal background check from a reporting agency approved by BCT and Verida. Background checks required under this Section shall be national criminal background checks, as well as pursuant to TCA § 38-6-109.

Any provider, driver, attendant, or subcontractor who appears on the Tennessee Abuse Registry, Social Security Death Master File, U.S. Department of Health and Human Services Office of Inspector General’s List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM) exclusion list, or the TennCare Terminated Provider List shall be deemed ineligible to provide services under this Agreement. Verida shall confirm all drivers and attendants are screened against these databases prior to providing services and on an ongoing basis thereafter.

Notwithstanding the foregoing, Verida and BCT reserve the right, in their sole discretion, to deem any driver or attendant ineligible to provide services under this Agreement based on any other criminal offense, conduct, or background information that, in the judgment of Verida or BCT, renders the individual unsuitable to perform services or presents a risk to members, or may otherwise adversely affect the integrity of the services provided

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
19. Violations of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961, et seq., or a violation of a comparable state law.
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.
- Verida 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 Verida 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), Verida requires that the NEMT provider immediately remove the driver from providing service. Furthermore, Verida requires NEMT providers to perform urine screening for traces of illicit drugs for all drivers involved in accidents involving a NEMT member.
- Verida 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:
    - No conviction within the past ten (10) years for a major moving traffic violation such as driving while intoxicated or driving under the influence;
    - No conviction for reckless driving within the previous thirty-six (36) month period;
    - No conviction for leaving the scene of a personal injury or fatal accident within the previous thirty-six (36) months;
    - No conviction for a felony involving the use of an automobile within the previous twelve (12) months;
    - 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;
    - 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
    - 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 Verida that drivers immediately notify the NEMT provider and Verida of any moving traffic violation or if a driver's license is suspended or revoked.
- Drivers must maintain daily transportation logs (Transportation Reimbursement Form) in accordance with the instructions listed on the Transportation 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 Verida 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, Verida requires all NEMT Providers to submit documentation as evidence of compliance with all driver requirements. Verida will maintain a file on every authorized driver with copies of all required documentation. Additionally, Verida 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. Verida 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 Verida 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 Verida' 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 Verida 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 Verida. 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. Verida 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, Verida 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 TennCare*Select* 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 (Verida 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, the NEMT providers shall provide their drivers with a Verida approved ID badge to be worn around their neck whenever they are providing transportation services to BlueCare/TennCare*Select* members.

Verida shall track all NEMT driver training and certification expiration dates within the Verida NEMT database. Verida shall notify NEMT providers and drivers of impending certification expirations and/or notice of their compliance with annual training requirements. Verida shall require NEMT providers to require drivers to provide evidence of continuing education requirements as specified in the CRA and TSA. Verida 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.

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 Verida 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 Verida 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 Verida to examine and/or audit transportation 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 Verida.

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 Verida. The NEMT provider shall agree to provide Verida 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 Verida with proof of coverage at least in the amounts indicated. In addition, the NEMT provider shall indemnify and hold harmless Verida, 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:
    - Name and address of authorized agent;

- Name and address of insured;
- Name of insurance company;
- Description of policies;
- Policy Number(s);
- Policy Period(s);
- Limits of Liability;
- Name and address of State Agency as certificate holder;
- Signature of authorized agent;
- Telephone number of authorized agent;
- Details of non-filed special policy exclusions in comments section of the Certificate of Insurance;
- Sixty days notice of cancellation/non-renewal; and
- 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 Verida' 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 Verida to arrange for alternative transportation. An incident is defined as an occurrence, event, breakdown, or public disturbance that interrupts the transport, 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. Verida 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, Verida will notify BlueCare/TennCare*Select* and/or TENNCARE.

The NEMT Provider will provide a written accident report along with a post-accident drug/alcohol screen results to Verida within twenty-four (24) hours of the accident and the police report with five (5) business days. The NEMT Provider will also cooperate with Verida, BlueCare/TennCare*Select,* and/or TENNCARE during any ensuing investigation.

Verida 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.

Verida 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 Verida' Quality/Compliance Manager to easily monitor non-compliance trends among NEMT providers.

NEMT Provider Staff Orientation

Verida 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 Verida.

Verida' 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/. NEMT providers may contact BCT to obtain a hard copy at any time. BCT will contact Verida on a quarterly basis to incorporate any needed changes to the provider manual.

In addition, Verida 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

Verida' standard practice is to provide the NEMT provider with a transportation manifest two days before the date of service. The latest that a transportation 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 transportation.

Verida will send transportation manifests to a NEMT provider by a facsimile device or secure electronic transmission, at the option of the NEMT provider. Verida will ensure that provision of the transportation 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.

Verida will ensure that the transportation manifests supplied to NEMT providers will include all necessary information for the driver to perform the transportation, including but not limited to:

- Number assigned by Verida for approved transportation;
- NEMT provider name;
- The mode of transportation;
- MCO/BHO name;
- Enrollee's name;
- Enrollee's age;
- Enrollee's sex;
- Transportation date;
- Number of legs for the transport (e.g., one-way, round transportation, or multiple legs);
- Origin of transportation/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 transportation 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 Transportation Mileage

If any transportation assignments are made after a manifest has been issued, Verida will contact the NEMT provider by telephone to confirm that they will accept the transportation and then fax the transportation add-on information to the NEMT provider.

Claims and Payment Procedures

Verida has a streamlined process for receiving and verifying claims and for processing payments to NEMT providers. Verida' 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 transportation and obtain appropriate signatures using approved forms, e-forms, or other approved methods of claims submission as evidence of services provided utilizing Verida' 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 Verida
- The form or e-form is signed by the NEMT driver
- Each transportation includes a valid Verida transportation confirmation number
- The eligible NEMT member's name matches Verida transportation 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 Verida.

- Any required special rate documentation is attached.

NEMT transportation must be properly documented at the time service is rendered using a Verida' approved claim form or electronic claims methodology. NEMT providers are required to use Verida' Transport Reimbursement forms as the approved manual process or Verida' Transportation Reimbursement e-forms via computer tablets utilizing Verida' proprietary mobile technology. NEMT providers are required to use the method assigned by Verida. Both methods are described below:

Transportation Reimbursement e-Forms Submission Process: Submission of complete and accurate Transportation Reimbursement e-Forms is of utmost importance and is a prerequisite to payment for transportation as provided above.

1. Transportation Reimbursement e-Forms using the Verida 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.
2. In the unlikely event the electronic device fails to function properly, the provider must notify Verida and request permission to use paper claim forms until the problem with the device is resolved
3. Transportation Reimbursement e-Forms must be completed as follows:
    a. Verida assigned vehicle number (SETI decal number), tag number, and vehicle identification number (VIN) (last 4 digits only);
    b. Date of service (automatically recorded by device);
    c. Driver's name;

d. Driver's signature;
e. Member's name;
f. Member's signature (if able, or receiving facility);
g. Unique transportation confirmation number;
h. Pick-up time (automatically recorded by device);
i. Actual pick-up odometer reading;
j. Drop-off time (automatically recorded by device);
k. Actual drop-off odometer reading;
l. Mode of transportation (i.e. Stretcher, Wheelchair or Ambulatory);
m. Name of Escort and relationship to Member (if applicable); and
n. Name of Attendant (if applicable);
o. Transportation 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.

All claims must be certified by an authorized representative of the provider using Verida' claims processing web portal. This process requires the provider to verify the accuracy of claim data, and then submit the claim to Verida for processing. At this point the claim is automatically time stamped as received by Verida.

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 transportation 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 Verida' 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.

Transportation Reimbursement Form Instructions

Transportation 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 Verida on a weekly basis for processing provider payments. Payments for transportation 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 Verida.
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 Verida (inspection decal number).
7. Record the date of all transports listed on the form. A separate Transportation Reimbursement Form must be completed for each date transportation are rendered.
8. Record the Driver's full name. If the driver of a vehicle changes during the course of a day, a new Transportation Reimbursement Form must be completed for each driver.
9. The NEMT Driver should sign each form in the space provided.

Transportation Information:

For each scheduled transportation leg, complete the following information in the spaces provided. Up to seven transportation 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 transportation confirmation number issued by Verida.
3. Place a check mark in the Special Rate box if Verida has authorized a special rate for the transport. Special rates for demand transportations require that you submit a copy of Verida' 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 Transportation 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 transportation miles as listed on the transportation manifest
10. Obtain the member's signature in the space provided. A signature must be obtained for each leg of the transportation. 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.
11. If an escort is required to accompany the member, record the escort's name and their relationship to the member in the spaces provided.
12. If the transportation was unable to be completed as scheduled, indicate the status of the transportation by circling "C" if the transportation was canceled, or "NS" if the member was a "no-show".
13. A comments section is provided for the driver to make any notations concerning the transportation such as reason for cancellation, comments regarding no-shows, special circumstances, etc.

E-form Information

Verida 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 transportation. The Mobile Application captures all required transportation log information in an electronic format that is immediately transmitted to Verida via computer tablets. This technology provides real-time transportation 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 transport

The Daily Provider Transportation Log also captures free text notes in case of transportation cancellations, incomplete requests, member no-shows, or accidents and incidents. The Verida *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 transportation 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 transportation information is entered. Entering this information at a time other than the actual pick-up or drop-off will inaccurately record the data. Transportation with data inconsistent with manifests provided by Verida may be denied payment.

Once the data is collected using the mobile application and successfully transmitted to Verida, it is removed from the device and cannot be viewed again. Verida requires all transportation 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 transportation have been successfully submitted.

Encounter Data Elements Reporting and Records

Verida is required by BCT and TENNCARE to record and report specific encounter data elements concerning every transportation 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 Transportation 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 Verida at the following address:

Verida, Inc.
843 Dallas Highway
Villa Rica, Georgia 30180

NEMT providers are required to submit the original completed Transportation Reimbursement Forms/e-Forms on a weekly basis to Verida' Central Business Office. Verida publishes a NEMT Provider Payment Schedule quarterly which lists the date requirements for claims submissions and associated claim payment dates.

Verida' policy is to pay NEMT providers within thirty (30) days of undisputed (clean) invoice submissions. Verida 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 transportation are properly verified and documented Verida will generate and distribute payments to NEMT providers along with an itemized remittance document. Verida 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 Verida' 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 Verida.

Verida 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 Verida.
- 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, Verida shall make the payment not later than one of the following:
  - The time-frame specified in the provider agreement.
  - The tenth (10th) day of the calendar month.
  - Within 5 days of receiving the capitated payment and supporting remittance advise from BCT and or TENNCARE.
- Verida 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 Verida, 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 Verida, the NEMT provider must submit the dispute in writing to the Verida Reconciliation Manager. The written dispute must include the transportation confirmation number(s) and the reason(s) for the dispute. Claim disputes can be faxed, mailed, emailed, or hand delivered to Verida' 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 Verida, 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

Verida will make every effort to provide tickets/tokens/passes to a member in a manner that ensures receipt prior to the scheduled transportation.

If Verida cannot provide tickets/token/passes prior to the scheduled transportation, Verida will arrange alternate transportation.

NEMT Provider Transportation Agreements

Verida 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 Verida' 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.

Verida 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. Verida 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 Verida to terminate any NEMT Provider Agreement when TENNCARE and/or BCT determines it to be in the best interest of the State.

Verida 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.
- Transportation Manifests
- Urgent Transportation 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 Verida 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 Verida 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.

Verida 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 Verida 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 Verida 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 Verida and made available to TENNCARE and BCT and/or state officials upon request.

Verida 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 Verida 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 Verida and any Federal or state, county or local agency or other governmental entity under a contractual relationship with Verida.

Verida 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 Verida 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. Verida 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. Verida 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 Verida 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. Verida 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 Verida 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 Verida under agreement with BlueCare Tennessee.

Non-Discrimination Policy

Verida 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 sex, race, color, religion, national origin, ancestry, age, physical or mental disability, medical condition, pregnancy, marital status or any other prohibited biases in accordance with any applicable, federal, state or local laws.

Verida will take affirmative action to ensure that all employment practices such as advertising, recruitment, hiring, promoting, Verida-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/TennCare*Select* members have rights concerning their interaction with Verida and the NEMT services they receive. Verida employees and NEMT providers should be aware of the TENNCARE member rights and should abide by those rights when serving BlueCare/TennCare*Select* members.

General Rule – Verida 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/TennCare*Select* members.

1. 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.
2. 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.
3. Participate in Decisions - Each member is guaranteed the right to participate in decisions regarding his or her transportation, including the right to refuse transportation.
4. 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.
5. 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 Verida Inc.; the contracted NEMT providers or employees of Verida Inc. treats the member.

Verida also abides by member rights granted in the BlueCare or TennCare*Select* 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 TennCare*Select* 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 Verida 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/TennCare*Select.*
- 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/TennCare*Select,* or Verida.

Members also have the right to appeal any decision or action by Verida that adversely affects their transportation needs or their access to care. All appeal procedures are handled by BlueCare/TennCare*Select* 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/TennCare*Select* Member Services Department listed below.

BlueCare Member Services	1-800-468-9698
TennCare*Select* Member Services	1-800-263-5479

If a member requests to file an appeal or refuses to contact BlueCare/TennCare*Select* for further assistance, Verida will refer the member directly to the TENNCARE Solutions Unit to file an appeal.

If BlueCare/TennCare*Select* 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

Verida will cooperate with BlueCare/TennCare*Select* in the investigation of any transportation member appeal, and will provide any necessary information in order for BlueCare/TennCare*Select* to provide a timely and accurate response to the member(s).

Appendix B

Quality Assurance and Grievance Management

The goal of Verida' Quality Assurance Program is to assure that Verida and its network of transportation providers deliver the highest service quality possible to BlueCare/TennCare*Select* members throughout our contracted transportation service regions. This plan addresses the scope of services internal to Verida 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, Verida 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 Verida' Quality/Compliance staff members conducting in-field observations of transportation providers rendering services. All service providers operating within Verida network of transportation providers are observed periodically on a random, unannounced basis. Verida 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 transportation;
- Analysis of grievances;
- Driver licensure, driving record, experience and training;
- Enrollee safety;
- Enrollee assistance;
- Completion of driver transportation 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

Area of Responsibility	Quality Indicator	Performance Standard
NEMT Provider	Appropriate Level of Service	100% compliance
	Initial pick-up timeliness	Within 10 min of scheduled pick-up

Area of Responsibility	Quality Indicator	Performance Standard
	Drop-off timeliness	Within 10 min of scheduled drop-off
	Return pick-up timeliness	Within 60 min of notification
	Multi-load travel time	No more than 1 hour longer than direct transport
	Vehicle standards	100% compliance with health & safety requirements
	Driver appearance & conduct	100% compliance with requirements
	Provider no-shows	Less than 1%
	Grievance rate	Less than 0.1%

Grievance Resolution Management

Grievances from BlueCare/TennCare*Select* 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/TennCare*Select* 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/TennCare*Select* members.

Member Grievances

All NEMT member grievances received by Verida will be immediately forwarded to BCT as required in the NEMT agreement between Verida and BCT. Verida will cooperate with BCT in the investigation and resolution of all member grievances. Any member grievances referred to Verida by BCT for investigation will managed utilizing the same procedures as stated below. Verida 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 Verida. Verida Quality/Compliance Manager is responsible for management of the non-member grievance process. All grievances are recorded and tracked in Verida 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 Verida, 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.

Verida' 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 Verida 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 Verida Manager, and/or the subcontractor provider and develops a recommended resolution.
7. The Verida 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 Verida 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

Verida 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, this includes but is not limited to “coach and counsel” session with the providers driver and vehicle inspections if needed. Verida 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. Verida 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
- Transportation too long
- Improper wheelchair tie down
- Vehicle dirty
- Vehicle defect
- Vehicle heat or A/C problem
- Phone system problem
- Other grievance

Fraud Monitoring

Verida 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 transportation 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

transportation and problematic no-show provider payouts. We review and monitor our Public Transit Bus pass program to ensure members receive and use their passes.

Verida Quality/Compliance staff conducts on-going detection methods such as spot checks, record reviews, random claim audit reviews, transportation 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

Member	NEMT Provider	Healthcare Provider
Falsifying eligibility	Duplicate billing	Giving false information
Kickbacks	Falsifying invoices	Misrepresenting member need
Misrepresenting need	Billing round transportation on one-way transportation	
Card loaning (public transit)	Misrepresenting need	
Misrepresenting access	Non-covered destination	
	Misconduct by agency staff	
	Falsifying cost reports	
	Falsifying records	

Transportation Provider Corrective Actions

Verida Quality/Compliance staff conduct scheduled and random, unannounced vehicle inspections. Each inspection is documented on Verida' Vehicle Inspection Form 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/TennCare*Select* 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 Verida 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.

Verida Transportation Management software produces On-Time Performance reports for various service periods to measure compliance with pick-up and delivery standards. Verida conducts quarterly meetings with NEMT providers to discuss contract issues, performance, and other network issues.

Non-Compliant NEMT Providers

Verida will ensure that its NEMT providers are qualified to perform their duties as specified in Verida' NEMT Provider Agreement. This includes, but is not limited to, meeting applicable federal, state or local licensure, certification, or registration requirements. Verida 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 Verida 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

Passenger Assistance & Sensitivity Skills Training Program

January 2013

VEHICLE CONCERNS

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 AL 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.

WHEELCHAIR TYPES

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. (One lever to set, the other to release.) The travel chair conveniently collapses down to allow it to be laid on a bench seat in your vehicle.

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 truck 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 transportation 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.

DISABILITY AWARENESS

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

HEARING LOSS

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.

SPEECH DISABILITIES

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 care taker how much do they understand
- Ask the care taker what type of day are they having
- Ask the care taker 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

AGING

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

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/Verida 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.

HIDDEN DISABILITIES

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.

ACCIDENTS & EMERGENCIES

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.

BEHAVIOR MANAGEMENT

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

<u>Inwardly Directed</u>

- 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/Verida 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 D

Please refer to the TennCare website for details regarding NEMT requirements at the following link:

https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf

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XXVI. Attachment II: Tennessee Health Care Innovation Initiative (THCII) Provider Guide

Tennessee Health Care Innovation Initiative Provider Guide

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 mission is to reward health care providers for high quality and efficient treatment of medical conditions and help maintaining people's health over time.

The Tennessee Health Care Innovation Initiative has three strategies: Primary Care Transformation, Episodes of Care, and long-term services and supports.

1. Primary Care Transformation focuses on the role of the primary care provider in promoting the delivery of preventive services and managing chronic illnesses over time. The initiative has developed an aligned model for Patient-Centered Medical Homes (PCMH), Tennessee Health Link (THL) for TennCare members with the highest behavioral health needs as well as a shared care coordination tool that allows providers to identify and track the closure of gaps in care linked to quality measures.
2. 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.
3. 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. 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 websites specific to this effort as well.

- State of Tennessee: https://www.tn.gov/tenncare/health-care-innovation.html
- BlueCare Tennessee: https://bluecare.bcbst.com/providers/quality-care/thcii

Program Introduction:	Tennessee Health Care Innovation Initiative Program	<https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html>
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 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 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. 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.		
Reporting and Frequently Asked Questions	Tennessee Health Care Innovation Initiative Guide to How to Read Your Episode of Care Report	https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care/introduction-to-episodes.html
	Episode of Care Waves Description and Code Summary	<https://www.tn.gov/tenncare/health-care-innovation/episodes-of-care.html>
	Tennessee Health Care Innovation Initiative Frequently Asked Questions	<http://bluecare.bcbst.com/forms/Provider%20Forms/THCII%20FAQ.pdf>

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	https://bluecare.bcbst.com/forms/Provider%20Forms/EpisodeofCare_Risk_Adjustment_Methodology.pdf
Risk Factors and Weights	Tennessee Health Care Innovation Initiative Risk Factors and Weights	https://bluecare.bcbst.com/providers/quality-care/thcii
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.		
Episode Thresholds	Tennessee Health Care Innovation Initiative Threshold Level Methodology	Information pertaining to Episode Thresholds can be found under Episodes of Care and Other Resources at the following link: https://bluecare.bcbst.com/providers/quality-care/thcii
Gain-Sharing Limits	Tennessee Health Care Innovation Initiative Gain-sharing Limits	https://bluecare.bcbst.com/providers/quality-care/thcii
Quality Metrics	Tennessee Health Care Innovation Initiative Quality Metrics	Information pertaining to Quality Metrics can be found in the Executive Summary 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>
A BlueCare Tennessee episode of care reporting and gain or risk payment will be calculated based on a contract entity identifier as explained below:		
Contract Entity Identifier	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	

There are specific Lines of Business that were selected to participate in the Tennessee Health Care Innovation Initiative.	
Lines of Business affected	BlueCare
THCII Provider Dispute Resolution Process	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 Process. This procedure can be found on the BlueCare Tennessee Website at: https://bluecare.bcbst.com/providers/quality-care/thcii 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. Information regarding the Independent Review process developed by the State of Tennessee Department of Commerce and Insurance can be found 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.*

XXVII. Attachment III: BlueCare Tennessee Change of Ownership or Control (CHOW) Policy

The change of ownership or control requirements in this Policy only apply to facility and professional group provider types. It is the responsibility of the entity or person acquiring a provider to provide BCT at least 60 calendar days advance notice of any change of ownership (CHOW), which is defined as a (a) direct or indirect sale or other disposition of all or a majority of the assets of provider; (b) any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests, or shares of the provider's voting stock (or membership interests or other equity); (c) the lease of all or part of Provider's facility or (d) any other transaction that results in a change to the Provider's NPI, Medicaid ID, or Tax ID. When such advance notice is not furnished, payment to the provider may be impacted. The requirements under this policy are in addition to, and do not replace or supersede, any notice or approval requirements triggered by a CHOW, "Change of Control," or assignment that are set forth in the provider's agreement with BCT.

The person or entity acquiring a provider or more than 25% control of a provider is required to submit a CHOW notification using the Provider Change of Ownership Notification Form on BlueCare's website. The buyer must also furnish a copy of the executed bill of sale or purchase document (minus the purchase price) within five (5) business days of closing. Failure to provide this documentation within this timeframe, will result in the suspension of payments to the provider following the CHOW.

A representative of the Provider Network & Contracting (PNC) team will assist the person or entity that is acquiring provider in completing any applicable credentialing and contracting processes prior to the effective date of the CHOW. They will also advise the provider of any missing information or documentation.

The buyer may be given the option to assume the seller's provider agreement, enter into a new agreement, or a single case agreement at BCT's discretion. If BCT determines a new agreement is required, the rates of the seller are not guaranteed to transfer to the buyer.

Claims with dates of service prior to the effective date of the CHOW should be submitted using the provider's NPI, Medicaid ID and Tax Id prior to the CHOW. Once the CHOW transaction closes, all claims for dates of service after the effective date of the CHOW should be submitted using the provider's NPI, Medicaid ID, and Tax ID after the CHOW reflecting any change resulting from the CHOW.

Nursing Facilities Only

The person or entity acquiring a provider must indicate if they will be furnishing skilled nursing facility (SNF) services at an ERC rate for Ventilator Weaning, Chronic Ventilator Care, and/or Tracheal Suctioning in addition to standard nursing facility (NF) and SNF services. If the buyer is assuming the seller's contract, BCT will modify the existing provider agreement to mirror the purchasing provider's response. Each level of ERC reimbursement must be uniquely identified. The purchasing provider's license must indicate that the NF has been licensed to provide specialized ERC.

Claims Reimbursement

BlueCare Tennessee will reimburse providers involved in a CHOW transaction in accordance with requirements specified in the Contractor Risk Agreement (CRA) and TennCare's guidance for NF CHOWs. The buyer must enter into or otherwise have in effect both a participating agreement with the State and a provider agreement with BCT in order to participate in the Medicaid program. The provider will be assigned a Medicaid ID which is required to receive payment from BCT. If the buyer does not have a Medicaid ID that is associated with their NPI and Tax ID, a Network Manager will educate the provider on TennCare's registration process for obtaining a Medicaid ID.

Regardless of whether the provider notifies BCBST 60 days prior to the CHOW effective date or not, the following will apply:

- The network effective date will be the CHOW effective date.
- The BlueCare Utilization Management team will retroactively adjust prior authorizations as of the CHOW effective date.
- No claims will be reimbursed after the CHOW effective date until the buyer has an active Medicaid ID.

- If the buyer has a Medicaid ID and has executed a contract with BCT, claims for dates of service after the CHOW effective date will be reimbursed at 100% subject to all applicable payment terms under the agreement.
- If the buyer has a Medicaid ID but has not executed a contract with BCT, claims for dates of service after the CHOW effective date will be reimbursed at 80% subject to all applicable payment terms under the agreement.
- Once the buyer executes a contract, BCT will automatically adjust any claims paid at the non-participating rate of 80% to pay the additional 20% within 90 days.
- In the event the provider contract is terminated because of a change of ownership, BCT shall remain obligated to pay for reimbursable services rendered prior to termination of the contract and that become due after the contract is terminated subject to timely filing requirements.

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XXVIII. Attachment IV: Notice of Nondiscrimination

Protections

Discrimination is against the law. TennCare obeys federal and state civil rights laws. We don't discriminate on the basis of race, color, national origin including limited English proficiency and primary language, age, disability, or sex. TennCare doesn't exclude people or treat them less favorably (differently) because of race, color, national origin, age, disability, or sex.

Help You Can Get

Disability Related Help

TennCare provides people with disabilities reasonable modifications. Reasonable modifications are reasonable requests for changes to a rule, policy, practice, or service to help a person with a disability related need. TennCare has free auxiliary aids and services to communicate effectively with you. Auxiliary aids and services are types of help like:

- Qualified sign language interpreters and
- Written information in large print, audio, accessible electronic formats, letter reading, Braille, or other formats.

Language Help

TennCare offers free language help to people whose primary language is not English like:

- Qualified interpreters and
- Translations - Information written in other languages.

Who to Contact

TennCare Connect

Do you need help like applying or renewing your TennCare, need auxiliary aids and services, or language help to talk with TennCare? Call TennCare Connect for free at 855-259-0701.

TennCare's Office of Civil Rights Compliance

- Reasonable Modifications - If you need reasonable modifications, contact TennCare's Office of Civil Rights Compliance ("OCRC").
- Grievance/Complaint - If you believe that TennCare failed to provide these services, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance/complaint with TennCare's OCRC by email at HCFA.fairtreatment@tn.gov, mail at 310 Great Circle Road Floor 3W, Nashville, TN 37243, OCRC's website at https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, or calling 615-507-6474 (TRS 711). If you need help filing a grievance call TennCare Connect for free at 855-259-0701.

More Information

You can find forms, policies and more information about civil rights and help like for food or other things on OCRC's website: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Do you need help?

We have free auxiliary aids and services, like large print, to communicate effectively with you. Call us at 1-800-468-9736, (TRS: 711).

If you speak a language other than English, help in your language is available for free. We have free interpretation and translation services to help you.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-8----- (TRS/TTY:866-503-0264).

Arabic: ربيةعلا

وظةحلم: اذا ملكتت ةغللا ربيةعلا اتمدخ دةعاسملا ويةغللا رةفوتم لكلا انجام. اتصل مقبر: 1-800-468-9736

Chinese: 繁體中文

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-468-9736

Vietnamese: Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số

1-800-468-9736

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-468-9736 번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-468-9736 .

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-468-9736 .

Gujarati: ગુજરાતી

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો

1-800-468-9736 .

Laotian: ພາສາລາວ

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-468-9736

German: Deutsch

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-468-9736
Tagalog: Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-468-9736 .
Hindi: हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-468-9736 पर कॉल करें।
Russian: Русский ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-468-9736 .
Japanese: 日本語 「日本語を話す方は、通訳や翻訳などの言語支援サービスを無料で利用できます」
Persian: فارسی توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-468-9736 تماس بگیرید.
The Beneficiary Support System (BSS) helps people who are enrolled in the CHOICES, Employment and Community First (ECF) CHOICES, and the Katie Beckett program. They also help people who want to enroll into these programs. For help call 888-723-8193. The TennCare Program does not discriminate against people because of their race, color, national origin including limited English proficiency and primary language, age, disability, religion, or sex. If you need reasonable modifications or think you were treated differently, or discriminated against you can file a grievance (complaint) with TennCare's Office of Civil Rights Compliance at HCFA.fairtreatment@tn.gov, https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html, 310 Great Circle Road Floor 3W, Nashville, TN 37243, or calling 615-507-6474 (TRS 711). Need help filing a grievance? Call TennCare Connect at 855-259-0701.

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