1915(c) Waiver Program Provider **Quick Reference Guide**

This *1915(c) Waiver Program Provider Quick Reference Guide* includes helpful information, including the following topics:

- Important phone numbers
- Benefits
- Claim submission guidelines
- Support coordinators
- The person-centered support plan (PCSP)
- Provider registration with the Division of TennCare

Tennessee | Long-term services and supports | Wellpoint: **833-731-2154**

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1915(c) Waiver programs

The 1915(c) Waiver includes three waivers: Statewide, Comprehensive Aggregate Cap (CAC), and Self-Determination. The waivers are approved by CMS pursuant to *Section 1915(c) of the Social Security Act*.

These waiver programs provide home- and community-based services (HCBS) not otherwise available under the State Plan to eligible persons with intellectual or developmental disabilities (I/DD) enrolled in such waivers. The 1915(c) Waiver programs are a part of the I/DD long-term services and supports (LTSS) program that offers HCBS to eligible individuals.

1915(c) Waiver program benefits

The Statewide Waiver, CAC Waiver and Self-Determination Waiver are closed to new referrals, with limited exceptions for the CAC waiver. Any member receiving services through the Self-Determination Waiver that requires support beyond what that waiver offers may be referred to the Employment and Community First CHOICES (ECF CHOICES) program. The Statewide Waiver serves individuals participating in the State's Money Follows the Person (MFP) program, transitioning from an ICF/IID following a stay of at least ninety (90) days, and but for the availability of medical residential services through the waiver, would require placement in an ICF/IID.

- A full description of each waiver program can be found in the I/DD *MLTSS Supplemental Provider Manual* on our provider website at: **https://tinyurl.com/3tkjdcdp**
- The following long-term services and supports are available to 1915(c) Waiver members, per waiver program and subject to all applicable service definitions, benefit limits, and expenditure caps, when the services have been determined medically necessary by Wellpoint.

Benefit	Self-Determination	Statewide	CAC
Support Coordination (limited to 1 unit per month)		X	X
Transitional Case Management (limited to the last 180 consecutive days of the individual's institutional stay prior to being discharged and enrolled in the waiver)		X	X
Personal Assistance (limited to a maximum of 215 hours per month; out of state PA has same limits, and in addition-limited to a maximum of 14 days per calendar year)	X	X	X
Enabling Technology (limited to a maximum of $10,000 per member per two calendar years, including SMESAT)	X	X	X
Specialized Medical Equipment/Supplies and Assistive Technology (limited to a maximum of $10,000 per member per two calendar years, including ET)	X	X	X
Personal Emergency Response Systems (monitoring limited to 1 unit per month/12 units per calendar year)	X	X	X
Environmental Accessibility (limited to a maximum of $15,000 per person for 3 consecutive calendar years)	X	X	X
Supported Employment Individual — Benefits Counseling	X	X	X
Supported Employment Individual — Exploration	X	X	X
Supported Employment Individual – Discovery	X	X	X
Supported Employment Individual — Job Coaching (limited to actual need and cannot be billed for more hours than the individual has worked in a billing period; Stabilization and Monitoring is limited to 1 unit per month; all employment/day services combined are limited to a maximum of 240 units per a 14- consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Supported Employment Individual — Job Development (Job Development Plan/ Self Employment Plan limited to 1 unit per 1,095 days; Job Development Start -Up/Self Employment Start-Up limited to 1 unit per 365 days)	X	X	X
Supported Employment – Small Group (all employment/day services combined are limited to a maximum of 240 units per a 14 - consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Intermittent Employment and Community Wraparound (limited to no more than 160 quarter hour units in a 14-day billing period and no more than 3,888 quarter hour units/year limit)	X	X	X
Community Participation (all employment/day services combined are limited to a maximum of 240 units per a 14 - consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Facility-Based Day (may only be authorized for up to 6 months at one time; all employment/day services combined are limited to a maximum of 240 units per a 14 - consecutive-day billing period and 5,832 units per calendar year)	X	X	X
Non-Residential Homebound Support (24 units per day; limited to a maximum of 10 days in a 14 - day billing cycle and maximum of 243 days per person per calendar year)	X	X	X
Individual Transportation (limited to maximum of 31 days/units per month) Individual Transportation Consumer Direction limited to $225 per month)	X	X	X
Speech, Language, and Hearing (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X
Occupational Therapy (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X
Physical Therapy (limited to 1 assessment with plan development per month; 3 assessments per year per provider; 1.5 hours per day for services other than assessments)	X	X	X
Behavior Services (limited to 8 hours per assessment for completion of the behavior assessment; 2 assessments per calendar year * 6 hours per assessment for behavior plan development and staff training during the first 30 days following its approval; 2 assessments per year 5 hours for presentations at meetings per calendar year)	X	X	X
Orientation and Mobility Services (limited to 1 assessment with plan development per month; 3 assessments per year per enrollee per provider; and 52 hours of non -assessment services per calendar year)	X	X	X

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Benefit	Self-Determination	Statewide	CAC
Nutrition (limited to a maximum of six (6) visits per waiver participant per calendar year of which no more than one (1) visit per waiver program year may be a Nutrition Services assessment; services other than the assessment (e.g., service recipient -specific training of caregivers; monitoring dietary compliance and food preparation) shall be further limited to a maximum of one visit per day)	X	X	X
Nursing (limited to a maximum of 48 units (12 hours) per day)	X	X	X
Adult Dental (limited to a maximum of $5,000 per calendar year and a maximum of $7,500 per 3 consecutive calendar years)	X	X	X
Respite (limited to a maximum of 30 days per calendar year)	X	X	X
Behavioral Respite (limited to a maximum of 60 days per calendar year)	X	X	X
Semi-Independent Living (limited to 1 unit per month (monthly), 31 days per month (regular daily), and 30 days per month (enhanced daily))	X	X	X
Supported Living (limited to 31 days/units per month; 14 days per year for out of state services)		X	X
Residential Habilitation (limited to 31 days/units per month; 14 days per year for out of state services)		X	X
Family Model Residential (limited to 31 days/units per month; 14 days per year for out of state services)		X	X
Medical Residential (limited to 31 days/units per month; 14 days per year for out of state services)		X	X

Reportable event reporting and management

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

- In HCBS and ICF/IID programs, there are three 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, Wellpoint, FEA, and DDA, as applicable. DDA shall triage all allegations reported via the Abuse Hotline and/or via Reportable Event Form within two business days (unless pending results of medical assessment, laboratory test, expert opinion, or other determination) to determine the need for an investigation. The Event Management Coordinator (EMC) or designee shall provide all requested documentation and information as soon as possible to ensure the disposition is reached within the required 2 business days. Once a disposition is reached by DDA, the responsible provider is notified of the outcome via email by the on-call investigator.
- Providers are required to send a copy of the REF to the Independent Support Coordinator (ISC), or DDA Case Manager, as applicable to the person supported, for persons supported by a 1915(c)-state funded waiver. Although non-reportable events are not reportable to DDA or Wellpoint, providers are expected to document, perform data collection and trend analysis, and address these events internally as part of strategic quality improvement processes that lead to improved outcomes. Provider oversight for non-reportable events will continue to be monitored by DDA and/or the MCO during annual quality assurance surveys and/or recredentialing, as applicable.

Please email reportable events correspondence to Reportable Events Management at TN-REM@wellpoint.com and submit all reportable events through FormStack at **https://tinyurl.com/295rpxa8**.

Adult Protective Services (APS):
Phone: **888-277-8366** | Fax: **866-294-3961**

Child Protective Services (CPS):
Phone: **877-237-0004**

DDA investigations hotline — 24 hours a day, 7 days a week — for Tier 1 reportable events only:
888-633-1313 (Statewide)

Person-centered support plan (PCSP):

- For all 1915(c) Waiver programs, the person-centered support plan (PCSP) is developed by the Independent Support Coordinator (ISC) or DDA Case Manager, as applicable, and Circle of Support.
- Independent support coordination agencies are required to share all PCSPs with DDA per the required timeframes, Wellpoint will have access to all PCSPs for members receiving services through the 1915(c) Waivers and enrolled to receive services with Wellpoint.
- The PCSP is developed through the completion of the person-centered planning process and assessments.
- It is a comprehensive plan that includes individually identified employment, community living, and health and wellness goals.
- Providers serving members enrolled in a 1915(c) Waiver program are responsible for using the PCSP to ensure they are providing services in accordance with the PCSP and training staff to meet the individual needs of the person supported.
- The PCSP is not used to determine funding level but is a description of the person's support needs and individually identified goals that should evolve to meet and respond to changing support needs in a timely manner.

- The PCSP is signed by members, all other individuals, and providers responsible for its implementation and a copy of the plan is distributed to the member and his/her legal representative, if applicable, and other people involved in the plan.
- Additional information and requirements for the PCSP and process can be found in the *IDD MLTSS Supplemental Provider Manual* under the 1915(c) Waiver programs section.

Authorization/notification instructions

Services to members may be rendered only upon authorization by DDA, pursuant to an approved PCSP.

Any payment for services is limited to and in accordance with the approved PCSP or PCSP amendment for such services.

- Provider payment shall be contingent upon the satisfactory completion of authorized, approved service as specified in the PCSP or PCSP amendment.
- DDA will refuse payment to the Provider for services billed that are beyond the level of services authorized by DDA through PCSPs or PCSP Amendments, exceed payment rates for these services or are not billed to DDA within the appropriate time frame after the delivery of services.

Billing and claims submission

For information on provider claims submissions or payment disputes, review the *Managed Long-Term Services and Supports Intellectual and Developmental Disabilities (MLTSS IDD)* Provider Manual, **https://tinyurl.com/5n7xw7nm**

Our service partners

Department of Disability and Aging (DDA)	West Regional Office: **866-372-5709** Middle Regional Office: **800-654-4839** East Regional Office: **888-531-9876**
Tennessee Carriers* (nonemergency transportation)	**866-680-0633**
Availity	**877-334-8446**
TennCare Provider Operations Call Center	**800-852-2683**

Provider Services

Provider Services representatives are available to assist providers. Call **833-731-2154**. Please have your Wellpoint provider ID number and NPI number available when you call. Listen carefully and follow the appropriate prompts.

24-hour Nurse HelpLine

866-864-2544

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

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

We encourage you to tell your patients about Nurse HelpLine and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Our Member Services line (**833-731-2153**) offers free translation services for 170 languages and the use of a TDD line for members with difficulty hearing.

Electronic data interchange (EDI)

Availity is Wellpoint's designated electronic data interchange (EDI) gateway and e-solutions service desk. How to register with Availity Essentials:

- If you wish to submit directly, you can connect to the Availity EDI Gateway at no cost; go to **https://Availity.com** and select **REGISTER**. If you have any questions or concerns, please contact Availity Client Services at **800-AVAILITY** (**800-282-4548**).

Availity Essentials offers everything you need to do business with your payer; functionality includes:

- Acknowledgement and response reports for claims submissions.
- Email notification when a reconsideration has been finalized by Wellpoint.
- An appeals worklist of open submissions to check a reconsideration status.
- Claim submission.
- Eligibility and benefits.
- Claims status inquiry.
- Attachments.

Electronic funds transfer (EFT)/ electronic remittance advice (ERA) registration:

- Electronic claims payment through electronic funds transfer (EFT) is a secure and fast way to receive payment, reducing administrative processes. EFT deposits are assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.
- Use **enrollsafe.payeehub.org** to register and manage EFT account changes.
- Use Availity to register and manage account changes for ERA located at **https://Availity.com**. If you have questions, call Availity Client Services at **800-AVAILITY** (**800-282-4548**).

Provider registration with the Division of TennCare

The Division of TennCare collects *Disclosure of Ownership* information for new and existing providers, both provider persons and provider entities. Whether or not you are a new provider to TennCare or an existing Medicaid provider, you must register your information on the TennCare Provider Registration site at **https://www.tn.gov/tenncare/providers/provider-registration.**

Failure to maintain an active Medicaid ID through TennCare will impact a provider's ability to remain an in-network provider with Wellpoint and prevent claims from being paid the in-network rate..

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

Medical appeals

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

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TennCare Member Medical Appeals Unit:

TennCare Member Medical Appeals
P.O. Box 593
Nashville, TN 37202-0593

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

TennCare Member Medical Appeals will forward any valid factual disputes to Wellpoint for reconsideration. An *On Request Report* will be sent to Wellpoint by TennCare Member Medical Appeals requesting reconsideration of the member's appeal.

Learn more about Wellpoint programs
https://provider.wellpoint.com/tn

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