Wellpoint

Medicaid

This Employment and Community First **CHOICES** (ECF CHOICES)

Provider Quick Reference Guide includes information on 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

ECF CHOICES

ECF CHOICES is a managed long-term services and supports (MLTSS) program that offers home- and community-based services (HCBS) to eligible individuals with intellectual and developmental disabilities (I/DD) enrolled in the program in order to promote competitive employment and integrated community living as the first and preferred option.

ECF CHOICES benefits

Tiered benefit structure based on the needs of individuals enrolled in each group helps provide cost-effective services in order to serve more people over time:

- Eligible for the full array of covered benefits under the physical and behavioral health programs to include preventive care services (Early and Periodic Screening, Diagnostic, and Treatment; annual physical examination; etc.) as well as nonemergency medical transportation as
- necessary to get an individual to and from covered services
- Five benefit groups:
  - Essential family supports (Group 4)
  - Essential supports for employment and independent living (Group 5)
  - Comprehensive supports for employment and community living (Group 6)
  - Intensive behavioral family supports (Group 7)
  - Comprehensive behavioral supports for employment and community living (Group 8)
- Array of employment services and supports
- Designed in consultation with experts from the Office of Disability Employment Policy
- Intended to create a pathway to employment
- Wraparound services to support community integration
- No facility-based services
- Many new services, based on stakeholder input, intended to empower individuals and families toward independence and integration
- Benefits that are intended to focus on integrated care for individuals with I/DD who have co-occurring psychiatric or behavioral health needs

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Respite (up to 30 days per calendar year or 216 hours per calendar year only for persons living with unpaid family caregivers)	X	X	X		
Supportive home care (SHC)	X				
Family caregiver stipend in lieu of SHC (up to $500 per month for children under age 18; up to $1,000 per month for adults age 18 and older)	X				
Community integration support services	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training	X	X	X	X	
Assistive technology, adaptive equipment, and supplies (up to $5,000 per calendar year of assistive technology and enabling technology combined)	X	X	X	X	X
Enabling technology (up to $5,000 per calendar year of assistive technology and enabling technology combined) (Effective 9/1/2021)	X	X	X	X	X
Minor home modifications (up to $6,000 per project, $10,000 per calendar year, and $20,000 per lifetime)	X	X	X	X	X
Community support development, organization, and navigation	X			X	
Family caregiver education and training (up to $500 per calendar year)	X			X	
Familytofamily support	X			X	
Decision-making supports (up to $500 per lifetime)	X	X	X	X	X
Health insurance counseling and/or forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports		X	X		
Community living supports: family model		X	X		
Individual education and training (up to $500 per calendar year)		X	X		X
Peer-to-peer support navigation for person-centered planning, self-direction, integrated employment/self-employment, and independent community living (up to $1,500 per lifetime)		X	X		X
Specialized consultation and training (up to $5,000 per calendar year[1])		X	X		X
Adult dental services (up to $5,000 per calendar year; up to $7,500 across three consecutive calendar years)	X[2]	X	X		X

Benefit	Group 4	Group 5	Group 6	Group 7	Group 8
Employment services/supports	X	X	X	X	X
Supported employment: individual employment support: • Exploration • Benefit counseling • Discovery • Situational observation and assessment • Job development plan or self-employment plan • Job development or self-employment startup • Job coaching for individualized, integrated employment, or self-employment • Coworker supports • Career advancement	X	X	X	X	X
Supported employment (small group supports)	X	X	X	X	X
Integrated employment path services	X	X	X	X	X
Intensive behavioral family-centered treatment, stabilization, and supports				X	
Intensive behavioral community transition and stabilization services					X

1 For adults in Group 6 determined to have exceptional medical and/or behavioral support needs, and for adults in Group 8, specialized consultation services are limited to $10,000 per person per calendar year.

2 Limited to adults 21 years of age and older.

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:

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

Please email reportable event documentation and questions to ECF CHOICES Reportable Events Management at ECF-REF@wellpoint.com or fax to **844-759-5952** (fax only if email is not available).

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

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

Department of Intellectual & Developmental Disabilities investigations hotline — 24 hours a day, 7 days a week — for **Tier 1 reportable events only: 888-633-1313 (Statewide)**

Quality monitoring consultative and annual survey

The goal of the consultative survey process is to give providers an opportunity to become familiar with the quality monitoring process and the quality focus areas, outcomes, and indicators on the Quality Monitoring Tool. It is intended to give providers an opportunity to ask questions about the tool and get an understanding of expectations for future surveys.

The consultative survey performance level rating will be determined as follows:

- Best: 76 or higher
- Better than good: 51 to 75
- Good: 26 to 50
- OK: 1 to 25

The annual survey performance level rating will be determined as follows:

- Best: 81 or higher
- Better than good: 61 to 80
- Good: 31 to 60
- OK: 1 to 30

Each performance level rating will correspond with a preferred provider status, which is determined as follows:

- Most preferred: 81 or higher
- Highly preferred: 61 to 80
- Preferred: 31 to 60
- Not preferred: 1 to 30

Support coordinators:

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

Person-centered support plan (PCSP):

- The PCSP is developed through the 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 ECF CHOICES members are responsible for using the PCSP to ensure they are providing services in accordance with the PCSP and training staff to meet the individual needs of the person supported.
- The PCSP is not used to determine funding level but is a description of the person's support needs and individually identified goals that should evolve to meet and respond to changing support needs in a timely manner.
- Individual PCSPs must be reviewed, signed, and returned by the provider before beginning services.
- A copy of the PCSP will be provided to the member, the member's representative, the selected provider(s), and the member's PCP.
- The PCSP is the plan of care.

Authorization/notification instructions

Authorization is required for all ECF CHOICES services. Wellpoint will provide an authorization in accordance to the individual's PCSP. To request a non-EVV service authorization, please send an email to ltcprovreq@wellpoint.com and include the following information:

- Provider name/Wellpoint provider ID
- Individual name/Wellpoint subscriber ID
- Dates of service, service, and unit amount requested
- Individual schedule (for services monitored through electronic visit verification EVV)

Authorization request for EVV services must be submitted in the EVV system.

Billing and claims submission

To initiate billing for the approved reimbursement, a claim must be submitted based on the specified ECF CHOICES service type. Claims will be submitted in one of two ways — through the EVV database or through the Availity Portal claims system:

- EVV database: CareBridge*
- Non-EVV:
  - Submit a *CMS-1450* (*UB-04*) claim form through Availity.
  - Bill using federally assigned NPI and tax identification number.

CareBridge — Electronic visit verification (EVV) system

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

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

Wellpoint requires all contracted providers to use the EVV system for applicable services. At least one staff member with the contracted provider should monitor caregiver activity to ensure caregivers are in the individual's home providing services at the scheduled time agreed upon when the referral was accepted, including after-hours and weekends if an individual is scheduled to receive care during that time period.

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

ECF CHOICES claiming in CareBridge

Effective April 1, 2021, ECF CHOICES providers are able to submit claims for all ECF CHOICES services through CareBridge, in addition to Availity. The advantages of using CareBridge include:

- Real-time reporting.
- Access to authorizations.
- Streamlined billing.

Effective June 1, 2021, ECF CHOICES providers are required to submit the following outcome-based employment services via the CareBridge system. This includes submitting all outcome-based reports:

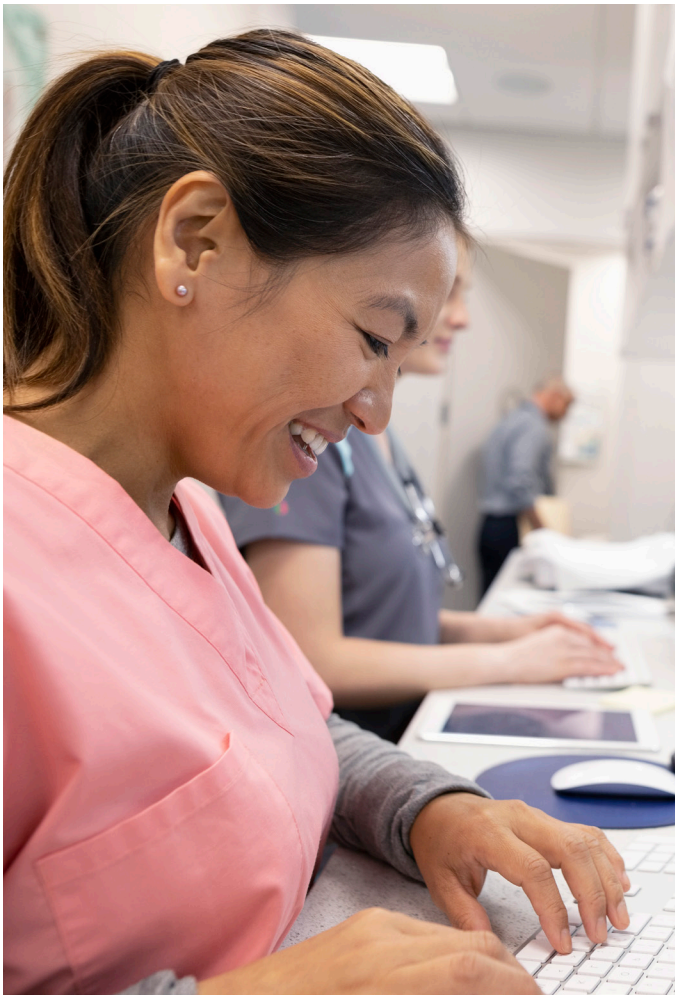
- Exploration — individual
- Benefits counseling
- Discovery — individual
- Situational observation and assessment — individual
- Job development plan
- Self-employment plan
- Job development start-up
- Self-employment start-up
- Career advancement
- Transition from small group to individual employment — **Note**, this is an incentive payment, not a *service*

Our service partners

CareBridge	**855-329-2116**
Tennessee Carriers* (nonemergency transportation)	**866-680-0633**
Availity	**877-334-8446**
Division of TennCare	**800-342-3145**

Local Provider Relations

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



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

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 healthcare needs.

Our Member Services line (**800-600-4441**) offers free translation services for 170 languages and the use of a TDD line for members with difficulty hearing.

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

Timely filing

Timely filing is within 120 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation, or in cases where a member has retroactive eligibility. In the case of coordination of benefits, timely filing is 120 days from the date of the primary carrier's *Explanation of Payment (EOP)*.

Electronic data interchange (EDI)

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

Availity's EDI submission options:

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

To become an EDI trading partner visit **Availity.com**. Login if already an Availity user, choose **My providers** > Transaction Enrollment or choose **Register** if new to Availity.

Please contact Availity Client Services with any questions at **800-Availity (282-4548)**.

Interactive care reviewer (ICR) tool via Availity Essentials:

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

Electronic claim payment reconsideration:

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

Availity Essentials functionality includes:

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

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

Electronic Remittance Advice (835)

The 835 eliminates the need for paper remittance reconciliation.

- Use Availity to register and manage ERA account changes with these three easy steps:
- Log in to **Availity** at **https://apps.availity.com/availity/web/public.elegant.login**
- Select **My Providers**
- Click on **Enrollment Center** and select **Transaction Enrollment**

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

Electronic funds transfer (EFT)

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

Starting November 1, 2021, Use EnrollSafe to register and manage EFT account changes.

Claims adjudication and dispute process:

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

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

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

Claim overpayments

For provider-identified claim overpayments, please follow the guidelines laid out in your Wellpoint contract and complete the *Overpayment Refund Notification Form* and submit to Wellpoint:

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

For claim overpayments identified by Wellpoint, please follow the directions on the overpayment request letter you receive from our Cost Containment Unit. Should you have any question on the overpayment request letter, please call the telephone number on your overpayment request letter. Please do not reach out to the NCC or your Provider Relationship Management representative unless you have exhausted all efforts with our Cost Containment Unit.

Provider registration with the Division of TennCare

The Division of TennCare is now collecting *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 will need to register your information on the TennCare Provider Registration site at **https://www.tn.gov/tenncare/providers/provider-registration**.

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

Medical appeals

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

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

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

TSU will forward any valid factual disputes to Wellpoint for reconsideration. An *On Request Report* will be faxed to Wellpoint by TSU requesting reconsideration of the member's appeal.

Learn more about Wellpoint programs
providers.wellpoint.com/tn/

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