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

This *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

TNWP-CD-076894-25 Matter #: 25-034

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 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 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 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

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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 (subject to limitations specified in the approved *1115 waiver and TennCare Rule*)	X	X	X	X	
Community transportation	X	X	X	X	
Independent living skills training (subject to limitations specified in the approved *1115 waiver and TennCare Rule*)	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)	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	
Family to family support	X			X	
Decision-making supports (up to $500 per lifetime)	X	X	X	X	X
Health insurance counseling forms assistance (up to 15 hours per calendar year)	X			X	
Personal assistance (up to 215 hours per month)		X	X		
Community living supports (CLS)		X	X		
Community living supports-family model (CLS-FM)		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 as specified below (subject to limitations specified in the approved *1115 waiver and in TennCare Rule*)	X	X	X	X	X
Supported employment: individual employment support: • Exploration – Individualized Integrated or Self-Employment • Benefits counseling • Discovery • Situational observation and assessment • Job development plan or self-employment plan • Job development startup 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 (IBFCTSS)				X	
Intensive behavioral community transition and stabilization services (IBCTSS)					X

1 For adults in Group 6 benefit group 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:

- 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. It is considered best practice to also notify the person's coordinator and legal representative/primary contact as events occur.
- 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 **stateoftennessee-cvlyz.formstack.com/forms/ref**.

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

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

Department of Disability & Aging 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

All DDA quality monitoring surveys, including the initial consultative survey and subsequent recurrent surveys, are intended to encourage, promote, and recognize quality within each provider organization. As such, the surveys are intended to be a positive, affirming, and constructive experience for providers; recognizing what they are doing that signifies quality and encouraging, as well as advising, them on how to further increase quality practices and outcomes. The quality monitoring surveys are focused on recognizing quality and do not promote a deficit-driven or policing culture but instead focus on measuring the quality of services based on the perspective of the people receiving services and the provider's practices.

Each indicator is scored on achievement levels:

- Needs development
- Additional refinement needed
- Met expectations
- Exceeds expectations
- Sets a new standard of performance
- Not applicable - N/A

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 with 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 to 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 system or through the Availity 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.

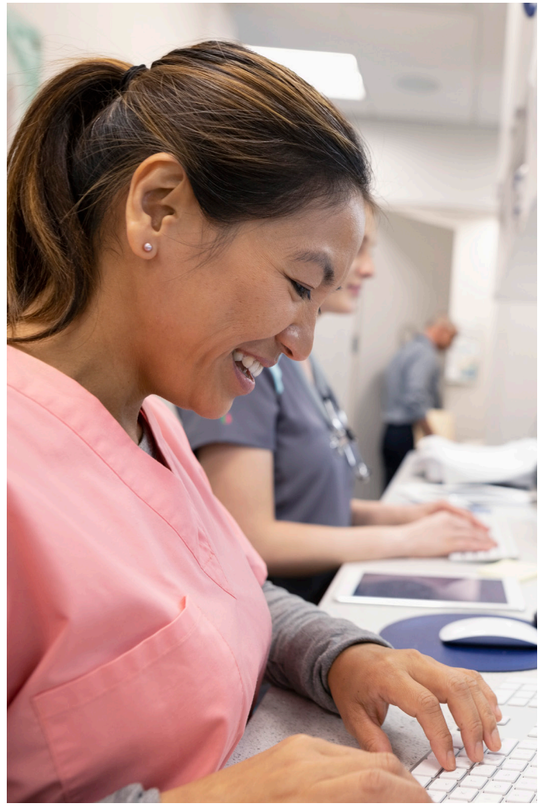
CareBridge — Electronic visit verification (EVV) system

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

ECF CHOICES providers can 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.

All LTSS Employment Report Templates have been revised and are available for download at **www.tn.gov/tenncare/long-term-services-supports/documents.html**. All providers of employment services were required to utilize the new templates for outcome-based employment services that started on May 1, 2024, or later. Those required templates include:

- Exploration- individual
- Exploration- Self Employment
- Benefits counseling
- Discovery — individual
- Situational observation and assessment — individual
- Job development plan
- Self-employment plan
- Job development start-up (all 3 phases)
- Self-employment start-up (all 3 phases)
- Career advancement (both phases)

There are also recommended templates for all non-outcome-based employment services. While the use of these specific templates is not required, they are strongly encouraged. These templates include the required components for service justification and continuation. Regardless of format, providers are required to submit documentation of these required components to the MCO Care/Support Coordinator each month. Those services include:

- Co-Worker Supports (Agreement and Service Log)
- Integrated Employment Path Service (Service Log)
- Job Coaching (Wage and Self Employment)
- Fading Plan for Job Coaching (required prior to re-authorization of the service)
- Supported Employment Small Group (Service Log)

Our service partners

CareBridge	**855-329-2116**
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.

Our provider website, provider.wellpoint.com/tn, offers you a full complement of online tools including:

- Enhanced account management tools.
- Detailed eligibility lookup tool with downloadable panel listing.
- More comprehensive downloadable member listing tool.
- Easier authorization submission tool.

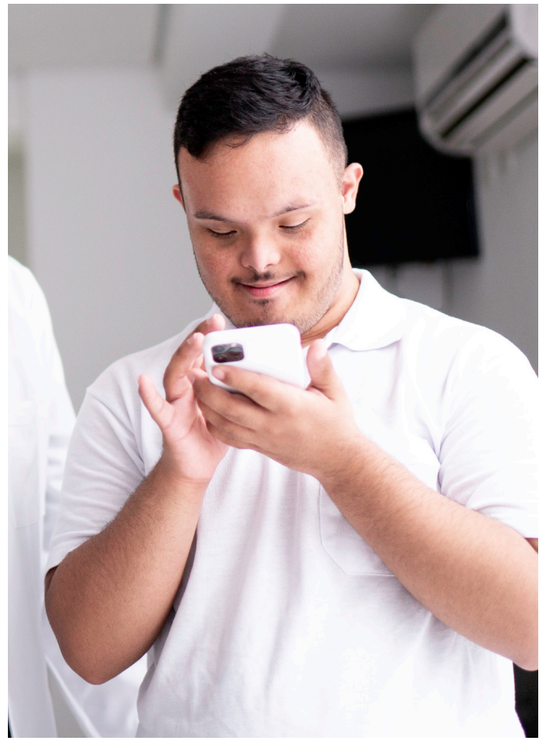
24-hour Nurse HelpLine 866-864-2544

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

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

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.



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 Wellpoint's 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 **https://www.availity.com**.

Login if already an Availity user, choose **My providers** > Transaction Enrollment or choose **Register** if new to Availity.

Availity Essentials multi-payer Authorization and Referral application:

- Your practice can initiate online precertification requests for
- ECF CHOICES members more efficiently and conveniently with our authorization and referral application, available through Availity Essentials.
- Both applications offer 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 and response reporting for claim 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
- Claim status inquiry
- Medical attachments
- Authorizations and referrals

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://www.availity.com**. If you have questions, call Availity Client Services at **800-AVAILITY (800-282-4548)**.

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. 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 **833-731-2154**:

- 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 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**.

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

Medical appeals

Members and their representative(s), including the member's provider, have 60 calendar days from the date 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 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: **866-771-7043**

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

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

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