Wellpoint | Tennessee

Provider Manual

Wellpoint

833-731-2154
provider.wellpoint.com/tn

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How to apply for participation

If you are interested in applying for participation with Wellpoint, please visit provider.wellpoint.com/tn or call Provider Services at 833-731-2154.

Medicaid services provided by Wellpoint Tennessee, Inc.

We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154.

Information about the civil rights laws can be found at tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

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1. INTRODUCTION

Welcome to the Wellpoint network provider family! Incorporated as Wellpoint Tennessee, Inc., we are pleased that you have joined our Tennessee network, which consists of some of the finest health care providers in the state.

The Division of TennCare administers the TennCare℠ program, which includes TennCare Medicaid, TennCare Standard and CoverKids. 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. CoverKids is TennCare's Children's Health Insurance Plan (CHIP) program, and it provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over. There is a special section of this manual to find CoverKids information — see chapter 21 for specific details.

We believe hospitals, physicians and other providers play a pivotal role in managed care. We can only succeed by working collaboratively with you and other caregivers. Earning your loyalty and respect is essential to maintaining a stable, high-quality provider network. All network providers are contracted with Wellpoint through a Participating Provider Agreement.

If you are interested in participating in any of our quality improvement committees or learning more about specific policies, please contact us. Most committee meetings are prescheduled at times and locations intended to be convenient for you. Please call Provider Services at 833-731-2154 with any suggestions, comments or questions that you may have. Together, we can arrange for and provide an integrated system of quality, coordinated and efficient care for our members and your patients.

Throughout the manual, references to the CRA are references to the MCO statewide contract available on the TennCare website at tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.

Division of TennCare required language — provider agreements
The Division of TennCare requires specific language in TennCare provider agreements. As noted in the provider agreement, TennCare required language and state of Tennessee mandates regarding the TennCare program can be updated by inclusion in this provider manual.

For ease of provider review, we've included certain required language and TennCare program mandates in a document titled "TennCare Regulatory Appendix, Division of TennCare Required Language — Provider Agreements," which is routinely appended to Wellpoint TennCare provider agreements. The latest version of this Appendix is also in Appendix C of this provider manual.

When Wellpoint amends your provider agreement to comply with federal and state regulatory requirements, most of these changes may be made within the body of this manual; however, in certain circumstances, those regulatory requirements may require Wellpoint to make changes to confidential portions of your provider agreement, such as the payment provisions. When this type of change is required, Wellpoint may provide you with a separate confidential notice of the regulatory changes to your provider agreement. If the payment provisions are impacted, we will send you a new

fee schedule or payment appendix for your records. If we provide you notice of changes in accordance with this paragraph, Wellpoint will limit such changes to those required to comply with the change in regulatory requirements.

Updates and changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most updated version is available online at provider.wellpoint.com/tn. To request a free, printed copy of this manual, call Provider Services at 833-731-2154.

If there is an inconsistency between the information contained in this manual and the agreement between you or your facility and Wellpoint, the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

2. OVERVIEW

Who is Wellpoint?
Wellpoint Tennessee, Inc., doing business as Wellpoint, is a leader in managed healthcare services for the public sector; the Wellpoint subsidiary health plans provide health care coverage exclusively to low-income families, children, pregnant women and Medicare Advantage Special Needs Plans.

Our mission
The Wellpoint mission is to provide real solutions for members who need a little help by making the health care system work better while keeping it more affordable for taxpayers.

Our vision
Wellpoint will be a different kind of health insurance company — a company that does well by doing good.

Our values
The Wellpoint values include:

- Compassion — We understand the importance of acting with empathy and developing meaningful relationships that will positively influence our associates and members' lives.
- Quality — We provide outstanding products, quality and unsurpassed service that, together, deliver premium value to our stakeholders.
- Integrity — We uphold the highest standards in all our actions.
- Teamwork — We work together across boundaries and in partnership to meet the needs of our customers and to help the company achieve its goals.
- Respect for people — We value our associates and their diversity, encourage their development and reward their performance.
- Good citizenship — We seek to find ways in which to engage and support the communities in which we live and work through volunteerism, political involvement and leading by example.
- Personal accountability — We keep our commitments to one another and to those we serve through accepting ownership for the quality of the work we produce. We have a strong desire to win in the marketplace and in every aspect of our business, and each associate accepts personal responsibility for achieving organizational success.

Strategy
The Wellpoint strategy is to:

- Improve access to preventive primary care services by ensuring the selection of a PCP who will serve as provider, care manager and coordinator for all basic medical services.
- Improve the health status and outcomes of the members.
- Educate members about their benefits, responsibilities and the appropriate use of health care services.

- Encourage stable, long-term relationships between providers and members.
- Discourage medically inappropriate use of specialists and emergency rooms.
- Commit to community-based enterprises and community outreach.
- Facilitate the integration of physical and behavioral health care.
- Foster quality improvement processes that actively involve providers in re-engineering health care delivery.
- Encourage a customer service orientation with regular measurement of member and provider satisfaction.

Summary

In a world of escalating health care costs, Wellpoint works to educate our members about the appropriate use of our managed care system and their involvement in all aspects of their health care.

3. QUICK REFERENCE INFORMATION

Wellpoint website
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.
- New provider data, termination, and roster tools

Wellpoint phone numbers
Please have your Wellpoint provider ID number and NPI number available when you call. Listen carefully and follow the appropriate prompts.

Provider Services telephone	833-731-2154
Provider Services fax	800-964-3627
TRS users	711
Automated provider inquiry line for member eligibility	833-731-2154
24-hour NurseLine	833-731-2153 (TTY 711)
Member Services	833-731-2153 (TTY 711)
Behavioral Health Services	833-731-2154
Behavioral Health Inpatient Authorization	Should be submitted electronically via provider.wellpoint.com/tn. If you prefer to paper fax, forms are available on the provider website: provider.wellpoint.com/tn
Behavioral Health Outpatient Services fax	866-920-6006
Behavioral Health Neuro-Psych fax	Should be submitted electronically via provider.wellpoint.com/tn. If you prefer to paper fax, forms are available on the provider website: provider.wellpoint.com/tn
After Hour Home Health/Private Duty Nursing Missed Visit Non-LTSS	615-316-2400 Ext. 1061261288
Wellpoint services for injectable and home infusion drug (prior authorizations only)	833-731-2154
Electronic Data Interchange (EDI)	Contact Availity Client Services 800-Availity (282-4548).
Durable Medical Equipment and Medical Supply Referrals — Wellpoint Utilization Management (UM)	833-731-2154

TennCare Online Services For additional assistance with logging into TennCare Online Services portal through MyTennCare Login page, please send an email to ProvSrvcs.Correspondence@tn.gov. https://www.tn.gov/tenncare/providers/verify-eligibility.html Providers and trading partners can: • Verify TennCare eligibility. • Upload or download *HIPAA* transactions. • Submit or inquire about pre-admission evaluation status. • Use the TennCare messaging system. If you cannot verify an enrollee's eligibility via this online system, you should contact the enrollee's TennCare MCO. You may also contact TennCare Provider Services at the phone numbers to the right. To access or download the User Guides for resetting passwords, adding staff accounts see TennCare Online Services Help.	800-852-2683 (toll free)
TennCare phone numbers	
Dental Services: DentaQuest is TennCare's dental benefits manager	855-418-1622 Dentaquest.com
TennCare Pharmacy	
OptumRx (toll free) for questions related to the pharmacy program and general prior authorization. Also, see the TennCare Pharmacy website: optumrx.com/oe_tenncare/landing	866-434-5524
TennCare Member Medical Appeals See also: tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html	800-878-3192
Mobile Crisis Services (behavioral health) operates 24 hours a day, 7 days a week and is open to anyone who needs mental health crisis services.	
Adults aged 18 and older	855-CRISIS1 or 855-274-7471 or 988 Suicide & Crisis Lifeline
Children under the age of 18, please call Youth Villages:	
Memphis region: Rural West TN: Rural Middle TN: Nashville region: Upper Cumberland: Southeast TN:	866-791-9226 866-791-9227 866-791-9222 866-791-9221 866-791-9223 866-791-9225

Knoxville region: Northeast TN:	866-791-9224 866-791-9228
TennCare Connect	855-259-0701
Fraud, Waste, and Abuse Reporting To report TennCare member or provider fraud or abuse:	Member Fraud and Abuse: 800-433-3928 or email at TennCare.Fraud@tn.gov Provider Fraud and Abuse: 833-687-9611 or email at Program.Integrity.TennCare@tn.gov Or TBI Medicaid Fraud Control Division At 800-433-5454 or email at: TBI.MedicaidFraudTips@tn.gov
To report provider or member fraud to WellPoint	Special Investigations Unit (SIU) Hotline at 866-847-8247 for provider or member fraud Visiting the SIU's fighthealthcarefraud.com education site; at the top of the page click "Report it" and complete the *Report Waste, Fraud and Abuse* form.
Tennessee Carriers (non-emergency transportation)	Wellpoint Call Center 866-680-0633 or https://tenncarriers.com/schedule/
TN Redline (offers help finding treatment or recovery options for addiction)	Call or text 800-889-9789

Ongoing provider communications
In order to ensure that providers are up-to-date with information required to work effectively with Wellpoint and our members, we provide frequent communications to providers in the form of broadcast faxes, provider manual updates, newsletters and information posted to the website.

Below, you will find additional information that will assist you in your day-to-day interaction with Wellpoint.

Additional information	
Member eligibility	Contact Provider Services at 833-731-2154.
Precertification/ notification	• May be telephoned, faxed, or submitted electronically to Wellpoint: – Telephone: 833-731-2154 – Fax: 800-964-3627

Additional information	
	– Electronically via provider.wellpoint.com/tn Behavioral Health Inpatient Fax: 844-452-8071 Behavioral Health Outpatient Fax: 866-920-6006 Behavioral Health Neuro-Psych Testing 844-451-2827
Precertification/ notification	• Data required for complete precertification/notification: – Member ID number – Legible name of referring licensed provider – Legible name of individual referred to provider – Number of visits/services – Date(s) of service – Diagnosis • In addition, clinical information is required for precertification Precertification forms are located at: provider.wellpoint.com/tn/resources/forms
Become a Tennessee Medicaid provider	You may access this information on the web. Go to tn.gov/tenncare/section/providers
National Provider Identifier (NPI)	NPI: The *Health Insurance Portability and Accountability Act* (*HIPAA*) of 1996 requires the adoption of a standard unique provider identifier for health care providers. All Wellpoint participating providers must have an NPI number. NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means that the numbers do not carry information about health care providers such as the state in which they practice or their specialty. Providers can apply for an NPI by: • Completing the application online at nppes.cms.hhs.gov (estimated time to complete the NPI application is 20 minutes) • Completing a paper copy by downloading it at nppes.cms.hhs.gov • Calling 800-465-3203 and requesting an application
Claims information	• Submit paper claims to: TN Claims P.O. Box 61010 Virginia Beach, VA 23466-1010 • Your organization can submit and receive the following transactions through Availity's EDI gateway:

Additional information	
	– 837 — institutional claims – 837 — professional claims – We do not accept dental claims, they will reject on the front end – 835 — electronic remittance advice (ERA) – 276/277 — claim status – 270/271 — eligibility request • Get started with Availity: – If you wish to submit electronic claims directly to Availity using your software or EMR system, setup is easy. Begin the process of connecting to the Availity EDI Gateway for your EDI transmissions by visiting the Availity EDI Clearinghouse page at Availity.com/ediclearinghouse. – If you wish to use another clearinghouse or billing company, please work with them to ensure connectivity. • For more information about Availity such as how to register, training opportunities and more, visit Availity.com or call 800-AVAILITY (800-282-4548). • Timely filing is within 120 days of the date of service except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Wellpoint receives notification from TennCare of the member's eligibility/enrollment. • A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. • For other claims (vision and pharmacy injectables), refer to the Services NOT Covered by Wellpoint section. (Noninjectable pharmacy benefits are covered by a Pharmacy Benefits Manager [PBM] contracted by TennCare.) • Wellpoint provides access to an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and referral authorization status. Visit provider.wellpoint.com/tn/.

Additional information	
	• If you are unable to access the internet, you may receive claims, eligibility, and referral authorization status over the telephone at any time by calling the toll-free automated Provider Inquiry Line at 833-731-2154. • Sign up with Availity to submit medical attachments using the Request for Additional information (RFAI) process. All requests will be viewable under the *Claims & Payment > Attachment New Application*. Simply locate the request and submit your attachment for immediate review.
Medical appeal information	• Member appeals are managed by TennCare. • Members have the right to file appeals regarding adverse benefit determinations taken by Wellpoint. For purposes of this requirement, appeal means a member's right to contest, verbally or in writing, any adverse benefit determinations taken by Wellpoint to deny, reduce, terminate, delay, or suspend a covered service; and any other acts or omissions of Wellpoint that impair the quality, timeliness, or availability of such benefits. An appeal may be filed by the member or by a person authorized by the member to do so, including a provider with the member's written consent. Complaint means a member's right to contest any other action taken by Wellpoint or service provider other than those that meet the definition of an adverse benefit determinations. Wellpoint will inform members of their complaint and appeal rights in the member handbook. Wellpoint has internal complaint and appeal procedures for members in accordance with TennCare rules and regulations, the TennCare waiver, consent decrees and court orders governing the appeals process. • You may call Wellpoint at 833-731-2153 (TTY 711) to speak to someone who is knowledgeable of appeal procedures and will facilitate all appeals as appropriate, whether the appeal is verbal or the member chooses to file in writing to TennCare. • Should a member choose to appeal in writing, the member will be instructed to file via mail or fax to the designated TennCare P.O. Box or fax number for medical appeals: TennCare Member Medical Appeals or CoverKids Member Medical Appeals P.O. Box 593 Nashville, TN 37202-0593 Fax (toll free) 888-345-5575 See also: tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html
Payment dispute process	We have several options when filing a claim payment dispute. They are described below:

Additional information	
	• Website (reconsideration and claim payment appeal): Wellpoint can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at Availity.com. Supporting documentation can be uploaded to Availity.com. You will receive immediate acknowledgement of your submission. Locate the claim you want to dispute on Availity using Claim Status from the Claims & Payments menu. If available, select Dispute Claim to initiate the dispute. Go to Request to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit. • Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to: Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599 • You may only submit one reconsideration and one appeal per claim. Multiple reconsiderations or appeals will not be accepted. • Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at 833-731-2154. Submit reconsiderations on the *Reconsideration Form* located at: provider.wellpoint.com/tn. Submit written claim payment appeals on the *Claim Payment Appeal* form located at: provider.wellpoint.com/tn.
Member complaints	The member (or a provider on behalf of the member if the issue is treatment/benefits) may file a complaint by phone by contacting Wellpoint at 833-731-2153 (TTY 711) or the Division of TennCare at 855-286-9085. The member may file a complaint regarding allegations of discrimination by contacting Wellpoint at 833-731-2153 (TTY 711).
Provider complaints	Wellpoint has a system for nonpayment-related complaints for network and non-network providers. See Section 20, Provider Complaint Procedures. File a provider complaint to: Wellpoint Attention: Operations Department – Provider Complaint 22 Century Boulevard, Suite 310 Nashville, TN 37214 As a participant in a program receiving federal funds, you should not be subjected to discrimination because of your race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses

Additional information	
	protected by federal and/or state law. A provider may file a complaint regarding allegations of discrimination online at: tn.gov/tenncare/members-applicants/civil-rights-compliance.html.
Case managers	• Wellpoint case managers are available during normal business hours from 8 a.m. to 5 p.m. Central time. • For urgent issues at all other times, call 833-731-2154.
Provider demographic updates	• Go online to: provider.wellpoint.com/tn • Contact the Tennessee Network Data Support at by email at tnnwksup@Wellpoint.com or fax to 877-423-9973 • Availity Essentials Provider Data Management (PDM) is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads. If you are not registered to use Availity Essentials, signing up is easy and 100% secure. There is no cost for your providers to register or to use any of the digital applications.
Community Resource Referrals	wellpoint.com/find-care/
Provider Experience Team	833-731-2154
Provider Service representatives	For more information or for hard copies of the guidelines and policies listed below, contact Provider Services at 833-731-2154.
Clinical Practice Guidelines	provider.wellpoint.com/tn See Resources > Policies, Guidelines and Manuals
Medical policies	provider.wellpoint.com/ttn/resources/policies-guidelines-and-manuals/medical-policies
Clinical UM Guidelines	provider.wellpoint.com/tennessee-provider/resources/policies-guidelines-and-manuals/medical-policies-and-clinical-guidelines
Web Portal client services	• Available Monday through Friday, 5 a.m. to 5 p.m. Pacific time at 800-Availity (800-282-4548), excluding holidays. • Email questions to support@availity.com
Language and Communication Assistances	• 833-731-2153

4. PROVIDER AND FACILITY DIGITAL GUIDELINES

Wellpoint understands that working together digitally streamlines processes and optimizes efficiency. We developed the Provider and Facility Digital Guidelines to outline our expectations and to fully inform Providers and Facilities about our digital platforms.

Wellpoint expects Providers and Facilities will utilize digital tools unless otherwise mandated by law or other legal requirements.

The Digital Guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Wellpoint. These platforms and applications are accessible to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

Digital and/or electronic transaction applications are accessed through these platforms:

- Availity EDI Clearinghouse
- B2B application programming interfaces (APIs)
- EMR connections

Digital functionality available through Availity Essentials include:

1. Acceptance of digital ID cards
2. Eligibility and benefit inquiry and response
3. Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
4. Claim submission, including attachments, claim status
5. Remittances and payments
6. Provider Enrollment and Network Management
7. Demographic updates

Additional digital applications available to Providers and Facilities include:

- Pharmacy prior authorization drug requests
- Services through Carelon Medical Benefits Management
- Services through Wellpoint BH

Wellpoint expects Providers and Facilities transacting any functions and processes above will use available digital and/or electronic self-service applications in lieu of manual channels (paper, mail, fax, call, chat, etc.). All channels are consistent with industry standards. All EDI transactions use version 5010.

Note: As a mandatory requirement, all trading partners must currently transmit directly to the Availity EDI gateway and have an active Availity Trading Partner Agreement in place. This includes Providers and Facilities using their practice management software and clearinghouse billing vendors.

Providers who do not transition to digital applications may experience delays when using non-digital methods such as mail, phone, and fax for transactions that can be conducted using digital applications.

Section 1: Accepting digital ID cards

As our members transition to digital Member ID cards, Providers and Facilities may need to implement changes in their processes to accept this new format. Wellpoint expects that Providers and Facilities will accept the digital version of the Member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

Section 2: Eligibility and benefits inquiry and response

Providers and Facilities should leverage these Availity clearinghouse hosted channels for electronic eligibility and benefit inquiry and response:

- EDI transaction: X12 270/271 – eligibility inquiry and response:
    - Wellpoint supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by HIPAA.
- Availity Essentials:
    - The Eligibility and Benefits Inquiry verification application allows Providers and Facilities to key an inquiry directly into an online eligibility and benefit look-up form with real-time responses.
- Provider desktop integration via B2B APIs:
    - Wellpoint has also enabled real-time access to eligibility and benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration opportunities.

Section 3: Prior authorization submission, attachment, status, and clinical appeals.

Providers and Facilities should leverage these channels for prior authorization submission, status inquiries and submit electronic attachments related to prior authorization submissions:

- EDI transaction: X12 278 – prior authorization and referral:
    - Wellpoint supports the industry standard X12 278 transaction for prior authorization submission and status inquiry as mandated per HIPAA.
- EDI transaction: X12 275 – patient information, including HL7 payload for authorization attachments:
    - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials:

- The Availity Essentials multi-payer Authorization application facilitates prior authorization submission, authorization status inquiry and the ability to review previously submitted authorizations.

- Provider desktop integration via B2B APIs:
  - Wellpoint has enabled real-time access to prior authorization APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Section 4: Claims: submissions, Claims payment disputes, attachments, and status

Claim submissions status and Claims payment disputes

Providers and Facilities should leverage these channels for electronic Claim submission, attachments (for both pre- and post-payment) and status:

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
  - Wellpoint supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Wellpoint supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
  - The Claims and Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - The Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online Claim payment disputes in most markets and for most Claims. It is the expectation of Wellpoint that electronic Claim payment disputes are adopted when and where they are integrated.
- Provider desktop integration via B2B APIs:
  - Wellpoint has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendors' practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

Providers and Facilities should leverage these channels for electronic Claim attachments from Availity.com:

- EDI transaction: X12 275 – patient information, including HL7 payload attachment:
  - Wellpoint supports the industry standard X12 275 transaction for electronic transmission of supporting Claims documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
  - The Claim Status application enables Providers and Facilities to digitally submit supporting Claims documentation, including medical records, directly to the Claim.
  - Digital Request for Additional Information (Digital RFAI) – the Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

Section 5: Electronic remittance advice and electronic Claims payment

Electronic remittance advice

Electronic remittance advice (ERA) is an electronic data interchange (EDI) transaction of the explanation of payment of your Claims. Wellpoint supports the industry standard X12 835 transaction as mandated per HIPAA.

Providers and Facilities can register, enroll and manage their ERA preference through Availity.com. Printing and mailing remittances will automatically stop thirty (30) days after the ERA enrollment date.

- Viewing an ERA on Availity Essentials is under Claims & Payments, Remittance Viewer. Features of remittance viewer, include the ability to search a two (2) year history of remittances and access the paper image.
- Viewing a portable document format (PDF) version of a remit is under Payer Spaces which provides a downloadable PDF of the remittance.

To stop receiving ERAs for Claims, contact Availity Client Services at 800-AVAILITY (282-4548).

To re-enable receiving paper remittances, contact Provider Services.

Electronic Claims payment

Electronic Claims payment is a secure and fast way to receive payment by reducing administrative processes. There are several options to receive Claims payments electronically.

- Electronic Funds Transfer (EFT)

  Electronic funds transfer (EFT) uses the automated clearinghouse (ACH) network to transmit healthcare payments from a health plan to a Provider's or Facility's bank account at no charge for the deposit. Health plans can use a Provider's or Facility's banking information only to deposit funds, not to withdraw funds. The EFT deposit is assigned a trace number (TRN) to help match the payment to the correct 835 electronic remittance advice (ERA), a process called reassociation.

To enroll in EFT: Providers and Facilities can register, enroll, and manage account changes for EFT through EnrollSafe at enrollsafe.payeehub.org. EnrollSafe enrollment eliminates the need for paper registration. EFT payments are deposited faster and are generally the lowest cost payment method. For help with enrollment, use this convenient EnrollSafe User Reference Manual.

To disenroll from EFT: Providers and Facilities are entitled to disenroll from EFT. Disenroll from EFT payments through EnrollSafe at enrollsafe.payeehub.org.

- Zelis Payment Network (ZPN) electronic payment and remittance combination

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to Zelis.com. Zelis may charge fees for their services.

  Note that Wellpoint may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  To disenroll from ZPN payment, there are two (2) options:

  - Enrolling for EFT payments automatically removes you from ZPN payments. To receive EFT payments instead of ZPN payments, enroll for EFT through EnrollSafe at enrollsafe.payeehub.org.

    OR

  - To disenroll from ZPN payments, update your Zelis registration on the Zelis provider portal or contact Zelis at 877-828-8770.

Not being enrolled for EFT or ZPN will result in paper checks being mailed.

Section 6: Provider Enrollment and Network Management

Provider Enrollment

Simplified enrollment process: Providers and Facilities can enroll as a new care provider in our network for professional, ancillary, institutional and facility provider types through Availity Essentials. Real-Time Tracking: Providers and Facilities can track the status of their requests in the My Dashboard section of the Provider Enrollment and Network Management application.

Contract Changes

Streamlined Contract Change Requests: Providers and Facilities can easily submit certain requests for contract changes through Availity Essentials:

- Amendments requests to add a network or line of business
- Change of Ownership notice
- Contract, line of business, or Network Termination requests
- TIN Change

Real-Time Tracking: Providers and Facilities can track the status of their requests in the My Dashboard section of the Provider Enrollment and Network Management application.

My Roster:

Providers and Facilities can download roster data through Availity Essentials. This allows the review of data within our system and updates using the formatted file to provide changes.

- To request a roster, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.
- Providers and Facilities will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.
- A Roster File Submission confirmation message displays. When the roster is ready to download, it will be available by clicking Download Requested Roster. Rosters are usually available within 4 hours. Rosters cannot be requested more than once a day.

Providers and Facilities can edit the downloaded roster and upload the updated version via Availity's Provider Data Management *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

**see Section 7: Demographic Updates section for more information about Provider Data Management.*

Provider and Facilities access for Provider Enrollment and Network Management features:

- To access these features, go to Availity.com > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management application.
- For organizations already using Availity Essentials, the organization's Availity Essentials administrator should go to My Account Dashboard from the Availity Essentials home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment and Network Management application need to be granted the role of Provider Enrollment.

Section 7: Demographic updates

Provider Data Management (PDM)

Availity Essentials Provider Data Management (PDM) is the digital intake application for Providers and Facilities to submit demographic change requests – it is also where providers can upload a roster with demographic changes. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters and follow the prompts.

For Provider and Facilities using the roster upload option, additional resources are available:

- Error Report:
    - Providers and Facilities can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.
    - Providers and Facilities are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems
- Results Report: When a roster has the status partially complete or complete a Results Report will be created for any rosters received on and after June 15, 2024. The Results Report is an Excel file that shows the adds and updates made to your provider group's demographic data based on the information contained in a specific roster.
- Use the *Roster Submission Guide*: For Provider and Facilities using the roster upload option, additional information about the Error Report and Results Report can be found in our *Roster Submission Guide*. Find it online at Availity.com > Payer Spaces > Select Payer Tile > Resources > Roster Submission Guide using Provider Data Management.

5. CREDENTIALING

Wellpoint uses the current National Committee for Quality Assurance (NCQA) Health Plan Accreditation Requirements for the credentialing and recredentialing of licensed independent providers with whom it contracts and who fall within its scope of authority and action.

Wellpoint will completely process credentialing applications within 30 calendar days of receipt of a completed credentialing application including all necessary documentation, attachments and a signed provider agreement. Complete process means that Wellpoint will review, approve and load approved applicants to its provider files in its claims processing system or deny the application and assure that the provider is not included in the Wellpoint provider network.

Credentialing

Each provider agrees to submit for verification all requested information necessary to credential or recredential providers who provide services in accordance with the standards established by Wellpoint. Each provider will cooperate with Wellpoint as necessary to conduct credentialing and recredentialing pursuant to Wellpoint policies and procedures.

Credentialing requirements

Each provider must remain in full compliance with the Wellpoint credentialing criteria as set forth in its credentialing policies and procedures and all applicable laws and regulations. Each provider will complete the Wellpoint application form upon request by Wellpoint. Effective January 1, 2018, use of the Council for Affordable Quality Healthcare's (CAQH) ProView will be required for initial credentialing and recredentialing with Wellpoint. ProView is a free online service that allows health care providers to fill out one application to meet the credentialing data needs of multiple organizations.

All providers applying for initial or continuing participation will be required to complete and submit their credentialing and recredentialing applications through CAQH ProView by accessing the CAQH website. Below are some helpful hints and things to remember when using ProView.

To join CAQH ProView:

1. Go to proview.caqh.org/pr.
2. Select Register Now on the bottom right and follow the instructions.

If you already participate with CAQH and have completed your online application, ensure you authorized Wellpoint access to your credentialing information.

Note: If you have selected Global Authorization, Wellpoint will already have access to your data.

To authorize Wellpoint:

1. Go to proview.caqh.org/pr and enter your username and password.
2. Select the cog wheel in the upper right and then select Authorize.
3. Scroll down, locate *Wellpoint* and check the box beside *Wellpoint*.

4. Select Save to submit your changes.

For questions about ProView, call the CAQH help desk at 888-599-1771 or email providerhelp@proview.CAQH.org.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Wellpoint
   - An independent relationship exists when Wellpoint directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Wellpoint's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of Wellpoint's primary Network and include Wellpoint Members who reside in the rental network area.
   - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Wellpoint credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan
- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
- Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Use Disorder Practitioners

Wellpoint credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings, including:
    - Adult Family Care/Foster Care Homes
    - Ambulatory Detox
    - Community Mental Health Centers (CMHC)
    - Crisis Stabilization Units
    - Intensive Family Intervention Services
    - Intensive Outpatient – Mental Health and/or Substance Use Disorder
    - Methadone Maintenance Clinics
    - Outpatient Mental Health Clinics
    - Outpatient Substance Use Disorder Clinics
    - Partial Hospitalization – Mental Health and/or Substance Use Disorder
    - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Use Disorder
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO
- Durable Medical Equipment Providers

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance) End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)
- Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics (ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Wellpoint's networks or plan programs is conducted by a peer review body, known as Wellpoint's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where a Wellpoint affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or a Wellpoint medical director designee and the vice-chair must be a lead medical officer or an Wellpoint medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Wellpoint's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the

process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Wellpoint may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Wellpoint will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Wellpoint will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Wellpoint will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Wellpoint will take appropriate action to track and eliminate those practices.

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Wellpoint when applying for initial participation in one or more of Wellpoint's networks or plan programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Wellpoint will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180-calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Wellpoint will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, DNV NIAHO, CIHQ or ACHC accredited hospital, or a Network hospital previously approved by the committee.

Verification Element
DEA/CDS and state-controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

RE-CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Wellpoint credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Wellpoint for review. If the candidate meets Wellpoint screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail

below, in the "Wellpoint Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

ONGOING SANCTION MONITORING

To support certain Credentialing Standards between the re-credentialing cycles, Wellpoint has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Wellpoint departments
- Any other information received from sources deemed reliable by Wellpoint.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

APPEALS PROCESS

Wellpoint has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Wellpoint's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Wellpoint may wish to terminate practitioners or HDOs. Wellpoint also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Wellpoint's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Wellpoint will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Wellpoint's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Wellpoint's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from

the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Wellpoint's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Wellpoint takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Wellpoint may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

WELLPOINT CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Wellpoint.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   - Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
   - Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
   - Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Wellpoint's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Wellpoint education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Wellpoint review and approval. Reports submitted by delegates to Wellpoint must contain sufficient documentation to support the above alternatives, as determined by Wellpoint.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (DNV NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Accreditation Commission for Health Care (ACHC) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.

7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

    a. It can be verified that this application is pending.
    b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA/CDS registration.
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources.
        - The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90-calendar day timeframe will result in termination from the Network.

    Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Wellpoint's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

    a. It can be verified that the applicant's application is pending; and
    b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
    c. The applicant agrees to notify Wellpoint upon receipt of the required DEA registration; and
    d. Wellpoint will verify the appropriate DEA/CDS registration via standard sources; and
    e. The applicant agrees that failure to provide the appropriate DEA registration within a 90-day timeframe will result in termination from the network.

    Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:
    a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
    b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
    c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring

hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.

12. No history of or current use of illegal drugs or history of or current substance use disorder.
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Wellpoint's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

    Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Participation Criteria and Exceptions for Non-Physician Credentialing.

The following participation criteria and exceptions are for non-MD practitioners. It is not additional or more stringent requirements, but instead the criteria and exceptions that apply for these specific provider types to permit a review of education and training.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.

c. Licensure to practice independently.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed mental health counselor (LMHC) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
   c. Practitioners with PhD training as a clinical psychologist can be reviewed.
   d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
   e. Licensure to practice independently or in states without licensure or certification:
      - Marriage & Family Therapists with a master's degree or higher:
        a. Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
      - Mental Health Counselors with a master's degree or higher:
        a. Provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) (proof of NBCC certification required) or meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

3. Pastoral Counselors:
   a. Master's or doctoral degree in a mental health discipline.
   b. Licensed as another recognized behavioral health provider type (e.g., MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
   c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
   d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

5. Clinical Psychologists:
   a. Valid state clinical psychologist license.

b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
   b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
   c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      - Transcript of applicable pre-doctoral training;
      - Documentation of applicable formal one-year post-doctoral training (participation in CEU training alone would not be considered adequate);
      - Letters from supervisors in clinical neuropsychology (including number of hours per week); or
      - Minimum of five years' experience practicing neuropsychology at least ten hours per week.

7. Licensed Psychoanalysts:
   a. Applies only to practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Wellpoint Credentialing Policy (e.g., psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      - Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
      - Meet examination requirements for licensure as determined by the licensing state.

8. Process, requirements and Verification – Nurse Practitioners:
   a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse

actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
   - Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
   - American Academy of Nurse Practitioners – Certification Program;
   - National Certification Corporation;
   - Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner);
   - Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
   - American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

   If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in Wellpoint's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. NPs will be clearly identified:
   - On the credentialing file;
   - At presentation to the CC; and
   - Upon notification to network services and to the provider database.

9. Process, Requirements and Verifications – Certified Nurse Midwives:
   a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
   b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force

adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
   - The National Certification Corporation for Ob/Gyn and neonatal nursing; or
   - The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.
f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
g. The CNM applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
h. Upon completion of the credentialing process, the CNM may be listed in Wellpoint's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. CNMs will be clearly identified:
   - On the credentialing file;
   - At presentation to the CC; and
   - Upon notification to network services and to the provider database.

10. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Wellpoint procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Wellpoint is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Wellpoint Health Plan and submitted for individual review by the CC.
f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, DNV NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
g. The PA applicant will undergo the standard credentialing process outlined in Wellpoint's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the PA may be listed in Wellpoint provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. PA's will be clearly identified:
   - On the credentialing file;
   - At presentation to the CC; and
   - Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Wellpoint's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state-controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a

Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or substance use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Wellpoint standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Wellpoint may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Wellpoint may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Wellpoint standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Wellpoint standards.

1. General Criteria for HDOs:

a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
b. Valid and current Medicare certification.
c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Wellpoint's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Wellpoint's other credentialed provider Networks.
d. Liability insurance acceptable to Wellpoint.
e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Wellpoint's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND WELLPOINT APPROVED ACCREDITING AGENT(S)

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, TCT, DNV NIAHO, ACHC, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, ACHC, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, DNV NIAHO, TJC, TCT
Home Infusion Therapy (HIT)	ACHC, CHAP, TCT, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC
Durable Medical Equipment Suppliers	TJC, CHAP, TCT, ACHC, BOC, HQAA

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	DNV NIAHO, ACHC, TJC, TCT
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC, ACHC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Use Disorder	ACHC, CARF, COA, DNV NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, ACHC, TJC

Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Use Disorder	CARF, DNV NIAHO, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder	CARF, COA, DNV NIAHO, ACHC, TJC

Facility Type (Behavioral Health Care - Rehabilitation)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	TCT, DNV NIAHO, ACHC, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Use Disorder Clinics	CARF, TJC, COA,

6. PRIMARY CARE PROVIDERS

Medical home

As a PCP, you serve as the entry point into the health care system for the member. You are the foundation of the collaborative concept known as a medical home. We promote this concept to all of our members.

- The medical home has an ongoing and collaborative relationship that consists of the:
- PCP.
- Member.
- Member's family.
- Health care providers within the medical home.
- Extended network of consultants, treating providers and specialists with whom the members of the medical home works.

Providers in the medical home know the special, health-related social and educational needs of the members and their families and are connected to necessary resources in the community that can assist in meeting those needs.

Primary care providers

The PCP is a network provider who has the responsibility for the complete care of his or her patient, our member. This practice holds true whether functioning as provider of that care or by referral to the appropriate provider within the network.

Providers with the following specialties can apply for enrollment with Wellpoint as a PCP:

- Family practitioner
- General practitioner
- General pediatrician
- General internist
- Geriatricians
- Nurse practitioners certified as specialists in family practice or pediatrics
- Federally qualified health centers and rural health centers

A provider cannot be both a specialist and a PCP; you must choose one or the other.

To participate in a TennCare managed care organization (MCO), the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Wellpoint.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a PCP before contracting with Wellpoint.

With the exception of members dually eligible for Medicare and TennCare, Wellpoint ensures that each member has an identified PCP who is responsible for coordinating the covered services provided to the member.

My PCP Connection
If a member is not dually eligible for Medicare and TennCare, Wellpoint will assign a PCP. The assigned PCP is responsible for providing care to their members and will not be reimbursed for services unless provided to a member assigned to themselves or their group. Wellpoint provides the member with an opportunity to change his or her PCP upon receipt of notice of PCP assignment. A member is issued a Wellpoint member identification card displaying the name of the member's PCP.

If a provider is contacted by a member who is either assigned to another PCP or who does not yet have an assigned PCP, the provider should have the member contact our Member Services department at
833-731-2153 (TTY 711) to request a PCP change or to be assigned a PCP. The member may complete a *PCP Change Request* form and fax it to us at 866-840-4993. The effective date of the new PCP assignment shall be based on the date of the member's signature on the PCP Change Form, or parent's or guardian's signature if the member is a child, when the form is received within three (3) business days of the date of signature on the PCP Change Form. In cases where the PCP Change Form is not received within three (3) business days of the date of the signature on the form, the effective date shall be the PCP Change Form date of receipt.

PCP Change form may also be sent electronically utilizing Availity.

Responsibilities of the primary care provider

The PCP is a network provider who has the responsibility for the complete care of his or her patients, our members, whether providing it himself/herself or by referral to the appropriate provider of care within the network. Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs. Below are highlights of the PCP's responsibilities.

The PCP shall:

- Manage the medical and health care needs of members, including monitoring and following up on care provided by other providers; provide coordination necessary for referrals to specialists, including behavioral health providers and fee-for-service providers (both in and out-of-network); and maintain a medical record of all services rendered by the PCP and other providers.
- Provide 24-hour-a-day, 7-day-a-week coverage and maintain regular hours of operation that are clearly defined and communicated to members.
- Provide services ethically and legally and in a culturally competent manner, meeting the unique needs of members with special health care needs.

- Ensure 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 CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Wellpoint or in the employment practices of the provider. Ensure notices of nondiscrimination are posted in conspicuous places available to all employees and enrollees.
- Participate in the systems established by Wellpoint that facilitate the sharing of records, subject to applicable confidentiality and *HIPAA* requirements.
- Implement policies and procedures for the provision of language assistance to members and/or the member's representative. Language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired and individuals with disabilities. Such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the TTY universal line). Providers will also employ appropriate auxiliary aids and services free of charge.
- Cooperate with Wellpoint and TennCare during discrimination complaint investigations and to report discrimination complaints and allegations to Wellpoint including allegations of discrimination set forth in Section A.2.12.21.1 and A.2.15.7.6.3.2.7 of the CRA.
- Assist TennCare members and/or member representatives in obtaining discrimination complaint forms and contact information for the Wellpoint nondiscrimination compliance office.
- Participate and cooperate with Wellpoint in any reasonable internal or external quality assurance, utilization review, continuing education, training, technical assistance or other similar program established by Wellpoint.
- Make reasonable efforts to communicate, coordinate and collaborate with specialty providers including behavioral health providers involved in delivering care and services to consumers.
- Participate in and cooperate with the Wellpoint complaint and grievance procedures when notified by Wellpoint of a member grievance.
- Not balance bill members, although PCPs are entitled to collect applicable copayments services.
- Continue care in progress during and after termination of his or her contract for up to 90 days until a continuity of care plan is in place to transition the member to another provider or to transition a pregnant member through postpartum care for pregnant members in their second and third trimester in accordance with TennCare requirements.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan regarding blood-borne pathogens in compliance with Occupational Safety and Health Administration (OSHA) standards.

- Meet the federal and state physical and web accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973 applicable to his or her practice location.
- Support, cooperate and comply with the Wellpoint Quality Improvement Program initiatives and any related policies and procedures designed to provide quality care in a cost-effective and reasonable manner.
  Inform Wellpoint if a member objects for religious reasons to the provision of any counseling, treatment or referral services.
- Treat all members with respect and dignity; provide members with appropriate privacy; and treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse the release of such records as allowed under applicable laws and regulations.
- Provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis.
- Give members the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
- Advise members about their health status, medical care or treatment options, including medication treatment options, regardless of whether benefits for such care are provided under the program.
- Advise members on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality patient care.
- Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention that is part of a clinical research study is clearly distinguished from entries pertaining to nonresearch-related care.
- Comply with the Tennessee Prescription Safety Act of 2012.
- Ensure the member is assigned to the provider's panel of members to provide services. This change can be made via fax (use *PCP Change* form) or by calling the NCC at 833-731-2154. Failure to follow this process/requirement will impact claim payment. The PCP change form may also be submitted electronically utilizing Availity.

Note: Wellpoint does not cover the use of any experimental procedures or experimental medications except under certain precertified circumstances.

Provider obligations

Wellpoint monitors the quality of services delivered under the provider agreement and initiates corrective action when necessary to improve quality of care. Services must be provided in accordance with either the level of medical, behavioral health or long-term care recognized as the acceptable professional standard of care in the respective community in which the provider practices and/or the standards established by TennCare.

Wellpoint will only pay providers for services provided:

- In accordance with the requirements of the Provider Agreement, Wellpoint policies and procedures, and state and federal law.
- To TennCare enrollees who are enrolled with Wellpoint.

Providers are obligated to:

- Maintain documentation necessary to demonstrate that covered services were provided in compliance with state and federal requirements.
- Ensure that any applicable authorization requirements are met.
- Verify that a person is eligible for TennCare on the date of service.
- Assist a member by providing appeal forms and contact information that include the appropriate address, telephone number and/or fax number for submitting appeals for state-level review.
- Coordinate with other TennCare contractors or Wellpoint subcontractors as may be requested by TennCare or Wellpoint.
- Conduct background checks on employees in accordance with Tennessee law, and such background checks should include at a minimum a check of the Tennessee Abuse Registry, Tennessee Felony Registry, National and Tennessee Sex Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS), and the HHS-OIG List of Excluded Individuals/Entities (LEIE).
- Maintain documentation verifying that the employee's name does not appear on the State Abuse Registry, State Felony Registry, the State and National Sexual Offender Registry, Social Security Master Death File, the EPLS, or LEIE. Individuals who do appear on one of the listed registries are excluded from participating in Medicaid, Medicare and other federal health care programs.
- All providers treating members with opioid use disorder must either provide medication assisted treatment (MAT) or have a policy for referral to a MAT provider for those members wishing to access MAT.
- Maintain all records as described in the Code of Federal Regulations Section 438.3(u) for a period not less than 10 years.

Providers who are compensated via a capitation arrangement are obligated to:

- Notify both Wellpoint and TennCare by certified mail, return receipt requested, if they become aware for any reason that they are not entitled to a capitation payment for a particular enrollee (e.g., a patient dies).

- Submit utilization or encounter data to ensure the ability of Wellpoint 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.
- Submit utilization or encounter data in a timely manner to support the individual services provided for obstetric care.
- Comply with fraud, waste and abuse requirements.
- Report suspected abuse, neglect and exploitation of adults in accordance with TCA 71-6-103.
- Report suspected brutality, abuse or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.
- Adhere to CareMore operational guidelines for designated Shelby County PCPs only. These guidelines are available in the TennCare CHOICES Long-Term Services & Supports (CHOICES) or Employment and Community First CHOICES (ECF CHOICES) Provider Manual Supplement link on our website, provider.wellpoint.com/tn, under the *Resources* heading.

Wellpoint may suspend, deny, and refuse to renew or terminate any provider agreement in accordance with the terms of the Wellpoint Agreement with TennCare and applicable law and regulation.

Both parties recognize that in the event of termination of the Agreement between Wellpoint and TennCare, providers will immediately make available to Wellpoint, 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 Wellpoint/provider agreement. The provision of such records will be at no expense to TennCare.

The TennCare Provider Independent Review of Disputed Claims process is available to providers to resolve claims denied in whole or in part by Wellpoint as provided at TCA 56-32-126(b).

PCP access and availability

All providers are expected to meet the federal and state physical and web accessibility standards and those defined in the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

Health care services provided through Wellpoint must be accessible to all members. Wellpoint is dedicated to ensuring that:

- The PCP or another physician/nurse practitioner is available to provide medically necessary services.
- Covering physicians follow the referral/precertification guidelines.
- The automatic direction of a member to the emergency room when the PCP is not available never occurs.

We encourage our PCPs to offer after-hours office care in the evenings and on weekends.

PCPs or extenders are required to adhere to the following access standards:

- Patient Load: 2,500 or less for physicians; half of physician extenders
- Appointment/wait times: usual and customary practice, not to exceed 15 business days from date of the patient's request for routine appointments and 48 hours for urgent care; wait times shall not exceed 45 minutes

To ensure continuous 24-hour coverage, PCPs must maintain one of the following arrangements for their members to contact the PCP after normal business hours:

- Have the office telephone answered after-hours by an answering service that can contact the PCP or another designated network medical practitioner. All calls answered by an answering service must be returned within 60 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP, directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or a designated Wellpoint network medical practitioner who can return the call within 60 minutes.
- An automated answering machine that directs the member to the practitioner or appropriate covering practitioner.

The following telephone answering procedures are not acceptable:

- Office telephone is only answered during office hours.
- Office telephone is answered after-hours by a recording that tells members to leave a message.
- Returning after-hours calls outside of 60 minutes.

PCP transfers

In order to maintain continuity of care, Wellpoint encourages members to remain with their PCP. However, a member may request to change his or her PCP for any reason by contacting our National Customer Care department at 833-731-2153 (TTY 711). The effective date of the PCP change will be the date of the request, unless the member has seen another assigned PCP on the same date. In this case, the effective date will be the next business day. The member may also complete a PCP Change Request Form and fax the request to 866-840-4993. The effective date of the new PCP assignment shall be based on the date of the member's signature on the PCP Change Form, or parent's or guardian's signature if the member is a child, when the form is received within three (3) business days of the date of signature on the PCP Change Form. In cases where the PCP Change Form is not received within three (3) business days of the date of the signature on the form, the effective date shall be the PCP Change Form date of receipt. Members can request a PCP change any day of the month. Members will receive a new ID card within 10 days.

Covering physicians/providers

During a provider's absence or unavailability, the provider needs to arrange for coverage for his or her members. The provider will either: (i) make arrangements with one or more network providers to provide care for his or her members or (ii) make arrangements with another similarly licensed and qualified provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the Network Provider Agreement, including without limitation, any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a member on the provider's behalf.

7. SPECIALTY CARE PROVIDERS

Specialty care providers

To participate in a TennCare MCO, the provider must have a Tennessee Medicaid provider number and be a licensed provider by the state before signing a contract with Wellpoint.

The provider must be enrolled in the TennCare Medicaid program at the service location where he or she wishes to practice as a specialist before contracting with Wellpoint.

Wellpoint contracts with a network of provider specialty types to meet the medical specialty needs of members and provide all medically necessary covered services. The specialty care provider is a network provider who has the responsibility for providing the specialized care for members, usually upon appropriate referral from a PCP within the network (see Roles and Responsibilities of the Specialty Care Provider). In addition to sharing many of the same responsibilities to members as the PCP (see Responsibilities of the PCP), the specialty care provider provides services that include:

- Allergy and immunology services.
- Burn services.
- Community behavioral health
- and substance use disorder) services.
- Cardiology services.
- Clinical nurse specialists, psychologists, clinical social workers — behavioral health.
- Critical care medical services.
- Dermatology services.
- Chiropractic
- Endocrinology services.
- Gastroenterology services.
- General surgery.
- Hematology/oncology services.
- Neonatal services.
- Nephrology services.
- Neurology services.
- Neurosurgery services.
- OB/GYN services.
- Ophthalmology services.
- Orthopedic surgery services.
- Otolaryngology services.
- Perinatal services.
- Pediatric services.
- Psychiatry (adult) services
- Psychiatry (child and adolescent) services
- Trauma services
- Urology services
- Lactation Services

Role and responsibility of the specialty care providers

Specialist providers will only treat members who have been referred to them by network PCPs (with the exception of mental health and substance use disorder providers and services that the member may self-refer) and will render covered services only to the extent and duration indicated on the referral. Obligations of the specialists include the following:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program

- Accepting all members referred to them
- Arranging for coverage with network providers while off-duty or on vacation
- Verifying member eligibility and precertification of services (if required) at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis, following a referral or routinely scheduled consultative visit
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval
- Coordinating care, as appropriate, with other providers involved in providing care for members, especially in cases where there are medical and behavioral health comorbidities or co-occurring mental health and substance use disorder disorders
- Ensuring 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 CRA, or be denied benefits of, or be otherwise subjected to discrimination in the performance of provider's obligation under its agreement with Wellpoint or in the employment practices of the provider
- Implementing policies and procedures for the provision of language assistance to members and/or the member representatives; language assistance services include interpretation and translation services and effective communication assistance in alternative formats such as auxiliary aids to any member and/or the member's representative who needs such services including but not limited to members with limited English proficiency, members who are hearing impaired, and individuals with disabilities; such services will be provided free of charge and be available in the form of in-person interpreters, sign language or access to telephonic assistance (e.g., the ATT universal line); providers will also employ appropriate auxiliary aids and services free of charge
- Cooperate with Wellpoint and TennCare during discrimination complaint investigations and report discrimination complaints and allegations to Wellpoint including allegations of discrimination set forth in Section A.2.12.21.1 and A.2.15.7.6.3.2.7 of the CRA available on the TennCare website at tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf.
- Assist TennCare members and/or the member representatives in obtaining discrimination complaint forms and contact information for the Wellpoint nondiscrimination compliance office. Members and/or their representatives may be referred to TennCare's Civil Rights Compliance webpage for more information about civil rights compliance, complaint forms, policies, and notices at: tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

The specialist shall also adhere to the requirements stated in the Responsibilities of the PCP section.

Specialty care provider access and availability

Wellpoint will maintain a specialty network to ensure access and availability to specialists for all members. A provider is considered a specialist if he/she has a provider agreement with Wellpoint to provide specialty services to members.

Access to specialty care
Wellpoint will ensure access to specialty providers (specialists) for the provision of covered services.

Availability of specialty care
Specialty care and emergency care
Referral appointments to specialists (e.g., specialty provider services, hospice care, home health care, substance use disorder treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate at the nearest facility available regardless of contract. Wait times shall not exceed 45 minutes.

General optometry services
Appointment/wait times: Usual and customary not to exceed three weeks for regular appointments and 48 hours for urgent care. Wait times shall not exceed 45 minutes.

OB/prenatal care
Appointments for OB/prenatal care visits must not exceed three weeks.

All other services not specified here will meet the usual and customary standards for the community.

Specialty referrals

In order to reduce the administrative burden on the provider's office staff, Wellpoint has established procedures that are designed to permit a member with a condition that requires ongoing care from a specialist provider or other health care provider to request an extended authorization.

The provider can request an extended referral authorization by contacting the member's PCP. The provider must supply the necessary clinical information that will be reviewed by the PCP in order to complete the authorization review.

On a case-by-case basis, an extended authorization will be approved. In the event of termination of a contract with the treating provider, the continuity of care provisions in the provider's contract with Wellpoint will apply. The specialist provider may renew the authorization by submitting a new request to the PCP. Additionally, Wellpoint requires the specialist provider or other health care provider to provide regular updates to the member's PCP. Should the need arise for a secondary referral, the specialist provider or other health care provider must contact Wellpoint for a coverage determination.

If the specialist or other health care provider needed to provide ongoing care for a specific condition is not available in the Wellpoint network, the referring physician shall request authorization from Wellpoint for services outside the network. Access will be approved to a qualified non-network health care provider within a reasonable distance and travel time at no additional cost if medical necessity is met.

If a provider's application for an extended authorization is denied, the member (or the provider on behalf of the member) may appeal the decision through the TennCare appeals process.

Second opinions

A member, parent and/or legally appointed representative, or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider (see provider referral directory) or a non-network provider if there is not a network provider with the expertise required for the condition. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Wellpoint may also request a second opinion at its own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during its regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

When Wellpoint requests a second opinion, Wellpoint will make the necessary arrangements for the appointment, payment and reporting. Wellpoint will inform the member and the PCP of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

8. COVERED HEALTH SERVICES

Wellpoint coordinates with other managed care organizations (MCOs) for members who have Medicaid with Wellpoint and another MCO for Medicare. Information regarding inpatient admissions and discharge planning as well as special requests for collaborative assistance is shared between the insurance companies. Members who have both Medicaid and Medicare (Medicare Advantage offered by Wellpoint) with Wellpoint are managed seamlessly at the health plan. Providers will continue to follow their current process for requesting prior authorization for services under Medicare Advantage offered by Wellpoint; requests will be processed for both Medicare coverage and Medicaid coverage as needed at the health plan.

Medically necessary services — medical necessity

Wellpoint uses these terms interchangeably. Medically necessary is defined by Tennessee Code Annotated, Section 71-5-144, and applies to TennCare enrollees. Implementation of the term "medically necessary" is provided in TennCare Regulations at Chapter 1200-13-16-.05. The regulations are consistent with the statutory provisions and control in case of ambiguity. No enrollee is entitled to receive, and TennCare is not required to pay for any items or services that fail to fully satisfy all criteria of medically necessary items or services, as defined either in the statute or in the medical necessity regulations at Sections 1200-13-13-.01(80), 1200-13-14-.01(85) and 1200-13-16-.05.

1. To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee and must satisfy each of the following criteria:
    a. It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee.
    b. It must be required in order to diagnose or treat an enrollee's medical condition.
    c. It must be safe and effective.
    d. It must not be experimental or investigational.
    e. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.
2. The convenience of an enrollee, the enrollee's family, the enrollee's caregiver or a provider shall not be a factor or justification in determining that a medical item or service is medically necessary.
3. Services required to diagnose an enrollee's medical condition:
    a. Provided that all the other medical necessity criteria are satisfied, services required to diagnose an enrollee's medical condition may include screening services as appropriate.
    b. Screening services are appropriate if they meet one of the following three categories:
        i. Services required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program

ii. Newborn testing for metabolic/genetic defects as set forth in the Tennessee Code Annotated, Section 68-5-401
iii. Pap smears, mammograms, prostate cancer screenings, colorectal cancer screenings, and screening for tuberculosis and sexually transmitted diseases including HIV, in accordance with nationally accepted clinical guidelines adopted by the Division of TennCare

c. Unless specifically provided for herein, other screening services are appropriate only if they satisfy each of the following criteria:

i. The Division of TennCare, a managed care contractor, or a state agency performing the functions of a managed care contractor determines the screening services are cost effective.
ii. The screening must have a significant probability of detecting the disease.
iii. The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person.
iv. Tests must be available at a reasonable cost.
v. Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect.
vi. Treatment in the asymptomatic phase must yield a therapeutic result.
vii. Services required to diagnose an enrollee's medical condition include diagnostic services mandated by EPSDT requirements.

4. Services required to treat an enrollee's medical condition:

a. Provided that all other elements of medical necessity are satisfied, treatment of an enrollee's medical condition may only include:

i. Medical care that is essential to treat a diagnosed medical condition, the symptoms of a diagnosed medical condition, or the effects of a diagnosed medical condition and which, if not provided, would have a significant and demonstrable adverse impact on quality or length of life
ii. Medical care that is essential to treat the significant side effects of another medically necessary treatment (e.g., nausea medications for side effects of chemotherapy)
iii. Medical care that is essential, based on an individualized determination of a particular patient's medical condition, to avoid the onset of significant health problems or significant complications that, with reasonable medical probability, will arise from that medical condition in the absence of such care.

Home Health Services

1. Prior Authorization for Home Health Nurse, Home Health Aide, and Private Duty Nursing Services must be obtained to establish the medical necessity of all requested services.

a. The following information must be provided when requesting authorization:

i. Name of physician prescribing the service(s);
ii. Specific information regarding the member's medical condition and any associated disability that creates the need for the requested service(s); and

iii. A letter of medical necessity must be provided with 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 patient 7:00 a.m., 12:00 p.m., and 5:00 p.m. daily; bathe patient once per day; administer medications three (3) times per day; catheterize patient as needed from 8:00 a.m. to 5:00 p.m. Monday through Friday; change dressing on wound three (3) times per week). This 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).

b. Updated orders must be obtained and submitted to the health plan when there is a change in services and at least annually.

2. Adult: Part-time or intermittent nursing services:

- Nursing services must be provided at no more than ONE visit per day, with each visit lasting less than eight (8) hours, and no more than 27 total hours of nursing care may be provided per week.
- Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week.
- On a case-by-case basis, the weekly total for nursing services may be increased to 30 hours, and the weekly total for nursing services and home health aide services combined may be increased to 40 hours for members qualifying for Level 2 skilled nursing care.
- Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a PRN (as needed) basis.
- Nursing services may include medication administration; however, a nursing visit will not be extended to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.

3. Pediatric: Part-time or Intermittent Nursing Services:

- Nursing services must be provided at no more than ONE visit per day, with each visit lasting less than eight (8) hours.
- Part-time or intermittent nursing services are not covered if the only skilled nursing function needed is administration of medications on a PRN (as needed) basis.
- Nursing services may include medication administration; however, a nursing visit will not be extended to administer medication or perform other skilled nursing functions at more than one point during the day, unless skilled nursing services are medically necessary throughout the intervening period.
- Limits for children may be exceeded when medically necessary.

- General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by the home care staff. Children typically have non-medical care needs which must be met, to the extent that home health services or private duty nursing

services are provided to a person under 18 years of age, a responsible adult (other than the health care provider) must be always present in the home during provision of home health or private duty nursing services unless all of the following criteria are met:

- The child is non-ambulatory; and
- The child has no or extremely limited ability to interact with caregivers; and
- The child shall not reasonable 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 during the time the skilled nurse is present in the home without the presence of another responsible adult) and
- No other children shall be present in the home during the time the home care nurse is present without the presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare-reimbursed home care services.

4. Adult and Pediatric: More than One Member Receiving Services in the Same Home:
   - If there is more than one person in a household who is determined to require TennCare-reimbursed home health nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple members in the same home and during the same hours if he/she can provide these services safely and appropriately to each member.

5. Adult and Pediatric: Home Health Aide:
   - Home health aide services must be provided as no more than two visits per day with care provided less than or equal to eight (8) hours per day.
   - If there is more than one person in a household who is determined to require TennCare-reimbursed home health aide services, it is not necessary to have multiple home health aides providing the services. A single home health aide may provide services to multiple enrollees in the same home and during the same hours if he/she can provide these services safely and appropriately to each enrollee.
   - Limits for children may be exceeded when medically necessary.
   - Home health aide services will not be approved to provide childcare services, prepare meals, perform housework, or generally supervise patients. Examples of appropriate home health aide services include, but are not limited to, patient transfers and bathing.

6. Adult: Home Health Aide:
   - Nursing services and home health aide services combined must total less than or equal to eight (8) hours per day and 35 or fewer hours per week. On a case-by-case basis, the weekly total may be increased to 40 hours for patients qualifying for Level 2 skilled nursing care.

7. Adult and Pediatric: Private Duty Nursing Services:

- These are nursing services for members who require eight (8) or more hours of continuous skilled nursing care during a 24-hour period.
- A member who needs intermittent skilled nursing functions at specified intervals, but who does not require continuous skilled nursing care throughout the period between each interval, shall not be determined to need continuous skilled nursing care.
- If there is more than one member in a household who is determined to require TennCare-reimbursed private duty nursing services, it is not necessary to have multiple nurses providing the services. A single nurse may provide services to multiple members in the same home and during the same hours, if he/she can provide these services safely and appropriately to each member.
- Non-skilled services may be provided by a nurse rather than a home health aide. However, it is the total number of hours of skilled nursing services, not the number of hours that the nurse is in the home, that determines whether the nursing services are continuous or intermittent.

8. Pediatric Private Duty Nursing Services:

Covered as medically necessary for children under the age of 21 in accordance with EPSDT requirements. Generally, only a child who is dependent on technology-based medical equipment requiring constant nursing supervision, visual assessment and monitoring of both equipment and child will be determined to need private duty nursing. However, determinations of medical necessity will continue to be made on an individualized basis.

General childcare services and other non-hands-on assistance such as cleaning and meal preparation shall not be provided by the private duty nurse. Because children typically have non-medical care needs which must be met, to the extent that private duty nursing services are provided to a person or persons under 18 years of age, a responsible adult (other than the private duty nurse) must be always present in the home during the provision of private duty nursing services unless all the following criteria are met:

- The child is non-ambulatory; and
- The child has no or extremely limited ability to interact with caregivers; and
- The child shall not reasonable 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 during the time the skilled nurse is present in the home without the presence of another responsible adult; and
- No other children shall be present in the home during the time the home care nurse is present without the presence of another responsible adult, unless these children meet all the criteria stated above and are also receiving TennCare reimburse home care services.

Members under the age of twenty-one (21) who require eight (8) or more hours of continuous skilled nursing care in a 24-hour period and are authorized to receive those services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed childcare; school and school-related activities; religious services and 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.

9. Adult: Private Duty Nursing Services:
    - Private duty nursing services are covered for adults aged 21 and older only 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.
    - An adult is using ventilator equipment or other life-sustaining medical technology if he:
        - Is ventilator dependent for at least 12 hours each day with an invasive patient end of the circuit (i.e., tracheostomy cannula); or
        - 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 to avoid or delay tracheostomy (requires medical review); or
        - Has a functioning tracheostomy:
            - Requiring suctioning; and
            - Oxygen supplementation; and
            - Receiving nebulizer treatments or requiring the use of Cough Assist/in-exsufflator devices; and
            - In addition, at least one subitem from each of the following items (I and II) must be met:
                - Medication:
                    - Receiving medication via a gastrostomy tube (G-tube); or
                    - Receiving medication via a Peripherally Inserted Central Catheter (PICC) line or central port; and
                - Nutrition:
                    - Receiving bolus or continuous feedings via a permanent access such as a G-tube, Mickey Button, or Gastrojejunostomy tube (G-J tube); or
                    - Receiving total parenteral nutrition.

10. Home health nurses, home health aides, and private duty nurses will never be authorized to personally transport a member. Home health nurses and aides delivering prior approved home health care services may accompany an enrollee outside the home in accordance with T.C.A. § 71-5-107(a)(12).

11. Private duty nursing services are limited to services provided in the member's own home, with the following two exceptions:

a. A member 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; or,

b. Work at his place of employment.

i. 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 those services in the home setting may make use of the approved hours outside of that setting when normal life activities temporarily take him outside of that setting. Normal life activity for a child under the age of twenty-one (21) means routine work (including work in supported or sheltered work settings); licensed child care; school and school-related activities; religious services and 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.

12. Private Duty Nursing and Caregivers:

- Private duty nursing services include services to teach and train the member and the member's family or other caregivers how to manage the treatment regimen.
- Having a caregiver willing to learn the tasks necessary to provide a safe environment and quality in home care is essential to assuring the member is properly attended to when a nurse or other paid caregiver is not present, including those times when the member chooses to attend community activities, and the above rules don't permit the private duty nurse or other paid caregiver to accompany the patient.
- To ensure the health, safety, and welfare of the member, and to receive private duty nursing services the member must have family or caregivers who:
  - Have a demonstrated understanding, ability, and commitment in the care of the member related to ventilator management, support of other life-sustaining technology, medication administration and feeding, or in the case of children, other medically necessary skilled nursing functions, as applicable; and
  - Are trained and willing to meet the recipient's nursing needs during the hours when paid nursing care is not provided, and to provide backup in the event of an emergency; and
  - Are willing and available as needed to meet the recipient's non-nursing support needs.
  - In the case of children under the age of 18, the parent or guardian will be expected to fill this role. In the case of an adult age 18 and older, if the health, safety, and welfare

of the individual cannot be assured because the recipient does not have such family or caregiver, private duty nursing services may be denied, subject to items (I) and (II) below. However, it shall be the responsibility of the MCO to:

- Arrange for the appropriate level of care, which may include nursing facility care, if applicable; and
- In the case of a person currently receiving private duty nursing services, facilitate transition to such appropriate level of care prior to termination of the private duty nursing service.

Electronic Visit Verification (EVV) System

EVV requirements of the 21st Century Cures Act are required for all home health and private duty services. Wellpoint is denying claims for intermittent home health skilled nursing, home physical, occupational, and speech therapy, private duty nursing, hourly home health nursing and aide services, where the home health agency treating any Wellpoint member is not using an Electronic Visit Verification (EVV) system.

This includes the following services and procedure codes but not limited to the below codes:

Service	Procedure Code
Private Duty Nursing	T1000
Hourly Home Health Nurse	S9123/S9124
Hourly Home Health Aide	S9122
Intermittent Home Health Skilled Nursing Visits	G0299/G0300
Intermittent Home Health Physical Therapy Visits	G0151/G0157
Intermittent Home Health Occupational Therapy Visits	G0152/G0158
Intermittent Home Health Speech Therapy Visits	G0153
Intermittent Home Health Home Health Aide Visits	G0156
Home Health Social Worker Visits	G0155

It is the Home Health Agency's responsibility to use CareBridge Health or implement a Third-Party EVV System with a data aggregator that interfaces with CareBridge Health. The EVV systems, at minimum, are required to track the following data elements per the Federal 21st Century Cures Act requirements:

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

Wellpoint EVV Vendor Contact Information
Tennessee EVV — CareBridge (carebridgehealth.com) carebridgehealth.com/tnevv Wellpoint Vendor — CareBridge Customer Support email: tnevv@carebridgehealth.com Customer Support: 844-482-0256 Caregiver IVR: 844-383-1678 Wellpoint EVV Support: TNEVV@Wellpoint.com

Personal care services

1. Personal care services are necessary to treat an enrollee's medical condition only if such services are ordered by the treating physician pursuant to a plan of care to address a medical condition identified because of an EPSDT screening. Personal care services must be supervised by a registered nurse and delivered by a home health aide. In addition, the services must:
    a. Be of a type that the enrollee cannot perform for himself or herself.
    b. Be of a type for which there is no caregiver able to provide the services.
    c. Consist of hands-on care of the enrollee.
2. Services that do not meet these requirements, such as general childcare services, cleaning services or preparation of meals, are not required to treat an enrollee's medical condition and will not be provided. For this reason, to the extent that personal care services are provided to

a person under 18 years of age, a responsible adult (other than the home health aide) must be always present during provision of personal care services.

a. The following preventive services:

i. Prenatal and maternity care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology
ii. Family planning services
iii. Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices
iv. Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d
v. Other preventive services that are required to achieve compliance with federal statutory or regulatory mandates under the EPSDT program
vi. Other preventive services that have been endorsed by the Division of TennCare or a particular managed care contractor as representing a cost-effective approach to meeting the medically necessary health care needs of an individual enrollee or group of enrollees

3. The Division of TennCare may make limited special exceptions to the medical necessity requirements described at TennCare Rule 1200-13-16-.05(1) for particular items or services such as long-term care, or such as may be required for compliance with federal law.
4. Transportation services that meet the requirements described at rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed medically necessary if provided in connection with medically necessary items or services.

* Note: Please reference the CHOICES or ECF CHOICES Provider Manual Supplement for information regarding personal care services provided under the CHOICES or ECF CHOICES program.

Wellpoint covered services

Physical health benefits chart

Service	Benefit limit
Abortions	Wellpoint will cover abortions only if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. • *Certification of Medical Necessity for* Abortion form, is available on TennCare's website, https://www.tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html

Service	Benefit limit
	Medical records and Certification of Medical Necessity form will be required for all abortion procedures. Should the claim be submitted for an abortion procedure without the required information, your claim will be denied.
Chiropractic services	Medicaid/Standard eligible, age 21 and older: Wellpoint will cover Chiropractic Services (spine manipulation only) by a chiropractor. Medicaid/Standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.
Chlamydia screenings	As medically necessary.
Dental services	Dental services will be provided to members by the Dental Benefits Manager (DBM) DentaQuest. (Note: As of 1/1/2026, the dental Provider will be transitioned to Renaissance) Facility, transportation, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR (Wellpoint) when the dental service is covered by the Dental Benefits Manager (DentaQuest) or through an HCBS waiver. BENEFIT FOR PERSONS AGED 21 AND OLDER (A) Diagnostic x-rays and exams; (B) Preventative cleanings; (C) Topical fluoride treatments and caries arresting medicament; (D) Restorative (fillings); (E) Endodontics; (F) Scaling and root planing; (G) Full mouth debridement; (H) Crowns; (I) Partial Dentures; (J) Complete dentures; (K) Immediate complete dentures and complete denture relines; (L) Tooth extraction; (M) Alveoloplasty; (N) Removal of lateral exostosis; (O) Removal of torus palatinus; (P) Removal of torus mandibularis; (Q) Palliative treatment; and (R) Nitrous oxide inhalation sedation. BENEFIT FOR PERSONS UNDER AGE 21 Preventive, diagnostic, and treatment services covered as medically necessary. Dental services under EPSDT are provided in accordance with the state's periodicity schedule as determined after consultation with recognized dental organizations and at other intervals as medically necessary. <u>Prevention</u> Oral exams (every six months) Teeth cleaning (every six months) X-rays Fluoride treatments Sealants (age requirements apply) <u>Treatments</u>

Service	Benefit limit
	Fillings Crowns Root canals Extractions (teeth removal) Please refer to the orthodontic section for additional information regarding orthodontic treatment. Note: The summary of benefits above is only intended for general informational purposes and may not reflect all updates or modifications to the plan benefits. For additional information on dental benefits, visit Dentaquest.com or call 855-418-1622.
Diabetic services	As medically necessary.
Durable medical equipment (DME)	As medically necessary. DME will be covered following TennCare rules, regulations, and clinical guidelines or medical policies. DME is reviewed for medically necessity. A prior authorization can be requested (if needed per PLUTO) by calling 833-731-2154, faxing referrals to 877-423-9958, or through the digital authorization application which is accessible through Availity.
Emergency air and ground ambulance transportation	As medically necessary.
Home Health Care	Covered as medically necessary as outlined in the home health section. Electronic Visit Verification (EVV) is required for all agencies to submit claims for home health care services.
Hospice care program	As medically necessary. Must be provided by a Medicare-certified hospice agency.
Hysterectomies	• Wellpoint will cover hysterectomies ~~only~~ if the following requirements are met: • The hysterectomy is medically necessary. • The member or her authorized representative, if any, has been informed orally and in writing that the hysterectomy will render the member permanently incapable of reproducing. • The member or her authorized representative, if any, has signed and dated a *Hysterectomy Acknowledgement* form, which is available on TennCare's website, https://www.tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html, prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age in accordance with federal requirements. The form will

Service	Benefit limit
	be available in English and Spanish. Assistance must be provided in completing the form when an alternative form of communication is necessary. Refer to the instructions on the *Hysterectomy Acknowledgement* form for additional guidance and exceptions. Wellpoint will not cover a hysterectomy under the following circumstances: • If it is performed solely for the purpose of rendering an individual permanently incapable of reproducing. • If there is more than one purpose for performing the hysterectomy, but the primary purpose is to render the individual permanently incapable of reproducing. • Ensure that all Hysterectomy claims are accompanied by Medical Records and the Hysterectomy Acknowledgement Form to avoid potential claim denial.
Inpatient hospital services	Medicaid eligible, age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services may be covered for adults as a cost-effective alternative at the sole discretionary authority of Wellpoint. Medicaid/Standard eligible, under age 21: As medically necessary, including rehabilitation hospital facility.
Lab and x-ray services	As medically necessary. Compliance with the *Clinical Laboratory Improvement Act* (*CLIA*) of 1988: Wellpoint will require that all laboratory testing sites providing services have either a current *CLIA* certificate of waiver or a certificate of registration along with a *CLIA* identification number. Those laboratories with certificates of waiver will provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests. Wellpoint will comply with the provisions of *CLIA*. If the provider performs laboratory services, the provider is required to meet all applicable requirements of *CLIA*. Please note that only contracted labs will be paid in addition to LabCorp and Quest OON's lab will require prior authorization.
Medical supplies	As medically necessary. Medical Supplies will be covered following TennCare Rules & Regulations, and Wellpoint clinical guidelines or medical policies. Requests for prior authorization (if needed per PLUTO) for medical supplies can be sent to Wellpoint Utilization Management (UM). Call 833-731-2154 or fax referrals to 877-423-9958. Providers may also use the digital authorization application which is accessible through Availity.

Service	Benefit limit
Nonemergency transportation (including nonemergency ambulance transportation)	As necessary to get a member to and from covered services, dental services (provided by the DBM) and pharmacy services (provided through the PBM) for enrollees not having access to transportation. If Wellpoint is unable to meet the access standards for a member, transportation must be provided regardless of whether the member has access to transportation. If the member is a child, transportation must be provided in accordance with TennCare Kids requirements. As with any denial, all notices and actions must be in accordance with the requirements of the TennCare CRA. Wellpoint requires 2 business day advance notice of the need for transportation to timely arrange transportation. Transportation must be coordinated through Tennessee Carriers at 866-680-0633.
Occupational therapy	Medicaid/standard eligible, age 21 and older: Covered as medically necessary when provided by a licensed occupational therapist to restore, improve, or stabilize impaired functions. Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.
Organ and tissue transplant and donor organ procurement	Medicaid eligible, age 21 and older: All medically necessary organ and tissue transplants, as covered by Medicare, are covered. Experimental or investigational transplants are not covered. Those covered include: • Bone marrow/stem cell. • Cornea. • Heart. • Heart/Lung. • Kidney. • Kidney/pancreas. • Liver. • Lung. • Pancreas. • Small bowel/multi-visceral. Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements. Experimental or investigational transplants are not covered.
Orthodontic services	Medicaid/standard eligible, under age 21 Orthodontic services must be prior authorized by the Dental Benefits Manager (DBM). Orthodontic services are only covered for individuals under age 21. Effective October 1, 2013, TennCare reimbursement for orthodontic treatment approved and begun before age 21 will end on the individual's 21st birthday. For individuals receiving treatment prior to October 1, 2013, such treatment may continue until completion as long as the enrollee remains eligible for TennCare.

Service	Benefit limit
	Orthodontic treatment is not covered unless it is medically necessary to treat a handicapping malocclusion. Cleft palate, hemifacial microsomia, or mandibulofacial dysostosis shall be considered handicapping malocclusions. A TennCare-approved Malocclusion Severity Assessment (MSA) will be conducted to measure the severity of the malocclusion. An MSA score of 28 or higher, as determined by the DBM's dentist reviewer(s), will be used for making orthodontic treatment determinations of medical necessity. However, an MSA score alone cannot be used to deny orthodontic treatment. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services.
Outpatient hospital services	As medically necessary.
Pharmacy services	Pharmacy services will be provided by the TennCare PBM unless otherwise described below. Wellpoint is responsible for reimbursement of specific covered injectable drugs administered in an office/clinic setting and for reimbursing providers providing both covered home infusion services and the drugs/biologics. Wellpoint requires that all claims for medications contain NDC coding and unit information to be considered for payment. Services reimbursed by Wellpoint will not include any pharmacy benefits otherwise covered by TennCare for pharmacy services.
Physical therapy	Medicaid eligible, age 21 and older: Covered as medically necessary when provided by a licensed physical therapist to restore, improve, or stabilize impaired functions. Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.
Physician inpatient Services	As medically necessary.
Physician outpatient services/community health clinic services/other clinic services	As medically necessary.

Service	Benefit limit
Preventive care services	Preventive services include initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. These services shall be exempt from TennCare cost sharing responsibilities. The following preventive medical services (identified by applicable CPT® procedure codes) are covered subject to any limitations described below, within the scope of standard medical practice and are exempt from any deductibles and copayments. Dental services and laboratory services not specifically listed below, which are required pursuant to the TennCare Kids program for persons under age 21, shall be provided in accordance with the TennCare periodicity schedule for such services. Office visits New patient 99381 — Initial evaluation 99382 — Age 1 through 4 years 99383 — Age 5 through 11 years 99384 — Age 12 through 17 years 99385 — Age 18 through 39 years 99386 — Age 40 through 64 years 99387 — Age 65 years and over Established patient 99391 — Periodic reevaluation 99392 — Age 1 through 4 years 99393 — Age 5 through 11 years 99394 — Age 12 through 17 years 99395 — Age 18 through 39 years 99396 — Age 40 through 64 years 99397 — Age 65 years and over Counseling and risk factor reduction intervention Individual 99401 — Approximately 15 minutes 99402 — Approximately 30 minutes 99403 — Approximately 45 minutes 99404 — Approximately 60 minutes Group 99411 — Approximately 30 minutes 99412 — Approximately 60 minutes Family planning services, if not part of a preventive services office visit, should be billed using the codes above. Prenatal/postpartum 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

Service	Benefit limit
	Other preventive services 96160 through 96161— Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument 90619 through 90750— Immunizations 92551 — Screening test, pure tone, air only (audiologic function) 96110 — Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument 99173 — Screening test of visual acuity, quantitative, bilateral Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (77057) as indicated in the US Preventive Services schedule.
Private duty nursing	Covered as medically necessary as outlined in the home health section above. Electronic Visit Verification (EVV) is required for all agencies to submit claims for home health care and private duty services.
Prosthetics and orthotics	As medically necessary.
Reconstructive breast surgery	Coverage for all stages of reconstructive breast surgery on a diseased breast because of a mastectomy, as well as surgical procedures on the non-diseased breast to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five years of the date the reconstructive breast surgery was performed on a diseased breast.
Renal dialysis Services	As medically necessary. Generally limited to the beginning 90-day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
Speech Therapy	Medicaid eligible, age 21 and older: Covered as medically necessary by a licensed speech therapist to restore speech (as long as there is continued medical progress) after a loss or impairment. The loss or impairment must not be caused by a mental, psychoneurotic or personality disorder. Medicaid/standard eligible, under age 21: Covered as medically necessary in accordance with TennCare Kids requirements.
Sterilizations	Sterilization means any medical procedure, treatment or operation done for the purpose of rendering a member permanently incapable of reproducing. Wellpoint will cover sterilizations only if the following requirements are met: • The member has given informed consent no less than 30 full calendar days (or no less than 72 hours in the case of premature delivery or emergency abdominal surgery) but no more than 180 calendar days

Service	Benefit limit
	before the date of the sterilization. The member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery. • The member is at least 21 years old at the time consent is obtained. • The member is mentally competent. • The member is not institutionalized (i.e., 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). • The member has voluntarily given informed consent on the approved *Sterilization Consent* form, which is available at tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html • The form will be available in English and Spanish. Wellpoint will provide assistance in completing the form when an alternative form of communication is necessary.
TennCare Kids services	Medicaid eligibles, age 21 and older: Not covered. Medicaid/standard eligibles, under age 21: Covered as medically necessary, except that the screenings do not have to be medically necessary. Children may also receive screenings in-between regular checkups if a parent or caregiver believes there is a problem. Periodic screenings, inter-periodic screenings, diagnostic and follow-up treatment services as medically necessary in accordance with federal and state requirements.
Vision services	Medicaid eligible, age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

Service	Benefit limit
	Medicaid/standard eligible, under age 21: Preventive, diagnostic and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements. Providers may contact EyeQuest at 800-526-9202 for more information. (Eye Vendor will be changing to Blue View Vision on 1/1/26.)

Services not covered by Wellpoint

For more information about services not covered by Wellpoint or TennCare Medicaid/Standard, please call Provider Services at 833-731-2154.

Refer to TennCare's benefit exclusions in the Exclusions section of the TennCare Rules:

- TennCare Medicaid at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm Find 1200-13-13-.10
- TennCare Standard at https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm Find 1200-13-14-.10

The services, products and supplies listed in the exclusion rules are excluded from coverage unless the rules require a medical necessity review for persons younger than 21 years. Some of the services may be covered under the CHOICES or ECF CHOICES programs or an HCBS waiver when provided as part of an approved plan of care in accordance with the appropriate TennCare HCBS rule.

Wellpoint has discretionary authority to offer medically appropriate cost-effective alternative services that are not covered under the mandatory benefit package on a case-by-case basis. Wellpoint may offer the medical care that Wellpoint and the health care provider deem appropriate in each individual case from a preapproved list of alternative services. An example of a cost-effective alternative service includes the use of a nursing home as a step-down alternative to continued acute care hospitalization. Wellpoint will follow all procedures in instances where it chooses to consider a cost-effective alternative service option.

Weight management

Members ages 10 and older who have a body mass index (BMI) ≥ 25 or who wish to make lifestyle changes that focus on healthy eating, behavioral management and increasing physical activity can be referred to the Population Health's Condition Care Program. The program is designed to encourage personal responsibility by actively engaging individuals in the management of their weight.

The member will be connected with a nurse who will partner with the member in achieving his or her weight loss goals. The case manager works closely with the member to assist in consulting with his or her physician to explore weight loss options and to determine the safest recommended approach to weight loss. The nurse will work collaboratively with the member and provider to develop a care plan and strategy to help the member be successful. The nurse will help locate facilities and programs in

the area that are available to support the member's decision to lose weight. Ongoing education about diet and exercise are provided over the phone and by mail. Monitoring the member's progress is an ongoing part of the service the nurses provide along with support and encouragement.

Members can be referred to Population Health's Condition Care program for weight loss by calling Member Services at 833-731-2153 (TTY 711).

Mid Cumberland region — nutritionist available by appointment
Dickson: 615-446-2839
Humphreys: 931-296-2231
Williamson: 615-794-1542
Rutherford: 615-898-7880
Stewart: 931-232-5329
Montgomery: 931-648-5747
Davidson: Matthew Walker Comprehensive Health Center: 615-327-9400 United Neighborhood Health Services: 615-620-8647

Pharmacy

Wellpoint is not responsible for the provision and payment of pharmacy benefits except as described below. TennCare contracts with a Pharmacy Benefits Manager (PBM) to provide these services. However, we coordinate with the PBM as necessary to ensure members receive appropriate pharmacy services without interruption. We monitor and manage both our contract providers' prescribing patterns and our members' utilization of prescription drugs. Providers identified as noncompliant as it relates to adherence to the PDL and/or generic prescribing patterns will be contacted by Wellpoint via letter, phone call and/or face-to-face visit. Wellpoint is responsible for reimbursement of specified injectable drugs administered in an office/clinic setting and to providers providing home infusion service. Providers must obtain precertification of these drugs by contacting the Wellpoint pharmacy department at 833-731-2154.

For all J-codes billed and all other codes representing billing for drugs, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:

- Vaccines for children which are paid as an administrative fee.
- Inpatient administered drugs.
- Radiopharmaceuticals unless the drug is billed separately from the procedure.

Additional information is located in Section 16, Claim Submission and Adjudication Procedures.

Services reimbursed by Wellpoint are not included in any pharmacy benefit limits established by TennCare for pharmacy services.

We require providers to inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

All providers should seek precertification/prior authorization from the pharmacy benefits manager when they feel they cannot order a drug on the TennCare Preferred Drug List (PDL), as well as take the initiative to seek precertification or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication).

TennCare's PBM is OptumRx. You can reference PDL information online at provider.wellpoint.com/tn. Drugs deemed self-injectable should be obtained through the TennCare pharmacy program. There are several drug products that are administered by intramuscular (IM) or intravenous (IV) route that, due to established channels of distribution, should be obtained through the designated specialty pharmacy. There may be instances where an emergency exists, the provider does not have access to the needed drug or a caregiver has been trained to administer the drug. In these situations, an override may be requested by calling or faxing OptumRx. The drug can be administered in the provider's office or another clinical setting.

For a list of drugs considered self-injectable available through the TennCare pharmacy program, please visit optumrx.com/oe_tenncare/landing.

Drugs that cannot be self-administered should be billed as a medical benefit to Wellpoint only after receiving precertification. Drugs given intravenously are considered nonself-administered by the patient. Drugs given by intramuscular injection may be presumed to be nonself-administered by the patient. Additionally, products whose package literature does not list or support self-administration are considered nonself-administered.

Wellpoint precertification requirements by procedure code are searchable through our Precertification Look-up Tool online at: provider.wellpoint.com/tennessee-provider/resources/precertification/precertification-lookup

Pharmacy copays
Pharmacy copays apply to all TennCare Standard members as well as non-institutionalized Medicaid adults who are eligible to receive pharmacy services in the TennCare program. Medicaid eligibles are exempt from nonpharmacy copays. These copays are administered by the PBM, who should be contacted directly for related questions or issues.

The pharmacy copay amounts are as follows:

Generic	$1.50
Brand name	$3.00

Pharmacy copayments do not apply to family planning services, pregnant women, enrollees in long-term care institutions (including HCBS) or members receiving hospice care. Members who are pregnant or receiving hospice care must self-declare at the pharmacy prior to obtaining any medications in order for the copay to be waived.

There are no annual out-of-pocket maximums.

The TennCare pharmacy manual

To help prescribers provide appropriate and timely drug treatment therapy, TennCare and OptumRx have written their own pharmacy manual. We strongly encourage you to regularly review this document online at https://www.optumrx.com/oe_tenncare/landing for the appropriate and current information concerning:

- Preferred drug list
- Clinical criteria for prior authorizations
- ICD-10 prior authorization bypass codes
- Prior authorization drug forms
- TennCare's auto-exemption list
- TennCare's prescriber attestation list
- Drug titration override list
- Covered over-the-counter medications
- Emergency supply medication list

Durable medical equipment and medical supplies

All DME and medical supplies that require precertification are reviewed and managed by the Wellpoint Utilization Management (UM) Department. Requests should be submitted to the health plan for review via:

- The digital authorization application which is accessible through Availity Essentials
- Fax to 877-423-9958.
- Phone at 833-731-2154.

Providers are encouraged to use the Precertification Lookup Tool to determine whether the item or procedure requires precertification. This feature can be found under the *Resources* tab on the provider self-service login page at provider.wellpoint.com/tennessee-provider/resources/precertification/precertification-lookup. Medical necessity is required for all services. All precertification requests must contain, at a minimum, the following information:

- First and last name of the patient
- Address where the service is to be rendered
- Patient or caregiver's phone number with area code
- Patient's date of birth and gender
- Current and clear physician orders
- Ordering physician's name and phone number
- Diagnosis and documentation to support the medical necessity of the requested service(s) or equipment (e.g., oxygen saturation levels for home O2)

- Allergies, disability status, height, weight, or diabetic status
- Desired date of service
- Services or equipment required including size, quantity, frequency, brand, etc.
- Details and description regarding the requested service or equipment including brand name, size, quantity, frequency and expected duration, etc.
- Wellpoint subscriber ID

Retroactive reviews or requests are not accepted by the health plan for review. If the code is a notification only code per PLUTO the provider may submit a retro request for authorization up to 120 days from date of service. If Wellpoint receives a claim for DME or medical supplies that normally require authorization and there is not a corresponding authorization on file, the claim will be denied.

Vision

Vision benefits are administered through EyeQuest. Providers may contact EyeQuest at 800-526-9202, Monday through Friday, 7 a.m. to 5 p.m. CT.

Providers must have a separate contract with EyeQuest to perform vision services. If Wellpoint receives claims for vision services that are not associated with a medical diagnosis, the claims will be denied, and the *EOP* will direct the provider to submit the claim to EyeQuest for services to be reimbursed.

Wellpoint offers vision coverage for:

- Medicaid eligible, age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered as medically necessary. This includes coverage for annual retinal eye examination to screen for diabetic retinopathy. Routine periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.
- Medicaid/standard eligible, under age 21: Preventive, diagnostic and treatment services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.

Nonemergency medical transportation

Nonemergency Medical Transportation (NEMT) benefits are managed by Tennessee Carriers. Providers may contact them at 866-680-0633 for more information. Services are provided in accordance with federal law and TennCare's rules and policies. Some restrictions apply to the NEMT benefit. Members needing to reschedule or cancel appointments must call Tennessee Carriers to cancel their ride.

- Starting July 1, 2025, trips must be scheduled at least 2 business days before the appointment, except for urgent trips, provider-initiated scheduling changes, and follow-up appointments that cannot be scheduled in advance.

- Providers should consider the distance from the member's home when making care referrals. Trips over 60 miles (90 for some specialists) require a medical reason and approval from TNNEMTOperations@wellpoint.com. Examples include:
    - A complex medical condition requiring specialty care with no nearby Wellpoint provider.
    - Ongoing treatment for a complex condition that prevents transitioning care to a nearer provider (e.g., transplant, cancer, major surgery).
    - Authorized treatment with a specific provider (e.g., inpatient psychiatric hospital).
- Members must begin scheduled trips from their home address.
- The NEMT Mileage Reimbursement Program follows the same geoaccess guidelines.
- MRP reimbursements will be made per household, not per member, if the appointment is the same date

Transporters must have a separate contract with Tennessee Carriers to perform nonemergency medical transportation services. If Wellpoint receives claims for nonemergency transportation services that are not coordinated through Tennessee Carriers, the claims will be denied, and the *Explanation of Payment* (*EOP*) will direct the provider to submit the claim to Tennessee Carriers for services to be reimbursed.

Ethical or religious directives and beliefs

If you are not providing the care or treatment a TennCare member needs or wants due to your ethical or religious directives or conscience and religious beliefs, please provide us with a list of the TennCare covered services that you or your organization does not deliver due to ethical or religious directives or conscience and religious beliefs. If and the TennCare member needs help finding a provider, please call us at 833-731-2153 (TTY 711). We can help the member find the care or treatment needed.

Please, inform the member that Wellpoint has additional information on providers and procedures that are covered by TennCare, and you are not required to make specific recommendations or referrals for that member.

9. TENNCARE KIDS MISSION

TennCare Kids mission

TennCare Kids is the name for Tennessee's Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) program. Tennessee has made a commitment to promoting good health in children from birth until age 21. TennCare Kids is a full program of health checkups and health care services for children with TennCare. These services make sure babies, children, teens, and young adults receive health care they need.

Providers are required to:

- Provide TennCare Kids services.
- Make appropriate TennCare Kids referrals and document the referrals in the member's medical record.
- Make arrangements for necessary follow-up when all of the components of screening cannot be completed in a single visit.
- Have a process for documenting services declined by a parent or legal representative that specifies the particular service that was declined.

Wellpoint will educate providers about proper coding and encourage them to submit the appropriate diagnosis codes identified by TennCare in conjunction with the evaluation and management (E&M) procedure codes for TennCare Kids services.

A child age 14 through 17 is presumed to be competent to seek his or her own medical care, to consent to release medical records, and to obtain transportation to and from medical services without the knowledge and consent of his or her parents or legal custodians. The child must be counseled by the provider to determine that the child actually is competent, and the record must reflect such determination by the provider. Release of medical records by an individual age 14 through 17 must be signed by the child. If it is determined that the child is incompetent, the services should not be provided without consent of the legal guardian or parent.

This determination of competency is essentially the same as an adult providing informed consent to receive health care services.

A child age 7 through 13 is presumed to be incompetent to seek his or her own medical care, etc. 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 seven is incompetent to seek his or her own medical care. No care can be provided without the consent of the parent or legal custodian.

Examples:

- Practitioners may treat juveniles with substance use disorder without prior legal guardian or parent consent.

- Practitioners should use their own discretion in determining whether to notify the child's legal guardian or parent.
- A practitioner may diagnose, examine and treat a minor without knowledge or consent of the legal guardian or parent for purposes of providing prenatal care.
- Contraceptive supplies and information may be supplied to a minor without consent of the legal guardian or parent.
- The practitioner may diagnose and treat STDs without the knowledge or consent of the parent or legal guardian. Legal reporting requirements to the Department of Health still exist.

To comply with the TennCare Kids requirements, transportation for a minor child may 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.

For members under 16 years of age seeking behavioral health TennCare Kids services and parent(s) or legally appointed representative is unable to accompany them to an examination, it is essential to ensure proper communication regarding the appointment. As per our contract requirement, please ensure that one of the following forms of communication is documented:

1. Direct Contact: You reach out to the member's parent(s) or legally appointed representative to discuss the examination findings and inform them about any recommended health care, diagnostic services, treatment, or necessary follow-up actions.
2. Notify the MCO: Alternatively, if direct contact is not feasible, kindly notify Wellpoint so we can communicate the results to the member's parent(s) or legally appointed representative. This process helps ensure that the family is well-informed and can make necessary arrangements for the member's continued care and well-being.

As always, please reach out to your provider relationship account manager or call Provider Services at 833-731-2154 if you have any questions about this communication or need assistance with any other item. If a member needs case management services, please also feel free to contact us via email: WLPBehavioralHealthRef@wellpoint.com

Referrals are not required for TennCare Kids members to access behavioral health providers. Members and their parents or guardians can request names of behavioral health providers from their PCPs.

TennCare Kids early and periodic screening
Wellpoint joins TennCare in this screening requirement. These early and periodic screening services are provided to members without cost. These screens will include periodic and interperiodic screens and be provided at intervals that meet reasonable standards of medical, behavioral and dental practice. 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 will be consistent with the screening guidelines recommended by the state, which are available at tn.gov/tenncare/tenncare-kids.html.

These include recommended screening guidelines for developmental/behavioral surveillance and screening, hearing screenings and vision screenings. *Preventive Visit* forms, *EPSDT and TennCare Kids Encounter Documentation* forms, and the *Tennessee Chapter of the American Academy of Pediatrics EPSDT/TennCare Kids* manual are also available on the following websites:

- tnaap.org/programs/epsdt-coding/epsdt-well-child-visits
- tnaap.org/programs/epsdt-coding/coding-resources
- tnaap.org/resources/developmental-behavioral-health-screening-tools
- tnaap.org/programs/epsdt-coding/oral-health

The screens include:

- Comprehensive health (physical and mental) and developmental history.
  - Initial and interval history
  - Developmental/behavioral assessment
- Comprehensive unclothed physical exam.
- Vision screening.
- Hearing screening.
- Laboratory tests.
- Immunizations.
- Health education/anticipatory guidance.

Providers must notify Wellpoint if a screening reveals the need for other health care services and if the provider is unable to make an appropriate referral for those services. In these cases, Wellpoint will make an appropriate referral and contact the member to offer scheduling assistance and transportation for members who lack access to transportation.

Wellpoint does not require precertification for periodic and interperiodic screens conducted by PCPs. Wellpoint will cover all medically necessary covered services regardless of whether the need for the services was identified by a provider who had received precertification from Wellpoint or a network provider.

Providers are encouraged to refer children to dentists by the time the first tooth appears in the mouth and no later than the first birthday.

TennCare Kids checkups can be provided by a child's PCP or local health department and include the following:

- Comprehensive health and developmental history
  - Physical
  - Behavioral/developmental
  - Dental
- Complete physical exam (unclothed)
  - Compare child's physical growth against what is considered normal for child's age.
- Vision screening
  - Includes age-appropriate vision assessment. Tools used for screenings shall be consistent with the screening guidelines.
- Hearing screening
  - Includes an age-appropriate hearing assessment. Tools used for hearing screenings shall be consistent with the screening guidelines.
- Lab tests
  - Blood lead test should be performed at 12 and 24 months; assessed at each visit beginning at 6 months. Children 36 to 72 months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning.
- Immunizations
  - Age appropriate and current status of shots in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule
- Health education
  - Anticipatory guidance (e.g., car seat safety, sex education, smoking, etc.)
  - Counseling parents and child regarding child's development

The periodicity schedule is recommended by the American Academy of Pediatrics. It indicates when screenings should be scheduled. Members are encouraged to contact their physician within the first 90 days of enrollment to schedule a checkup and within 24 hours after the birth of a newborn.

Infants/toddlers should have 12 TennCare Kids checkups before their third birthdays:

- Newborn
- 3-5 days of age
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months

Children 3-20 years of age should get a TennCare Kids checkup every year.

Tools recommended for use in TennCare Kids screenings

Measure	Age range	Description	Scoring	Accuracy	Time frame
Child Development Inventories (formerly Minnesota Child Development Inventories) (1992) Behavior Science Systems, Box 580274, Minneapolis, MN 55458 Phone: 612-929-6220	Birth to 72 months	Sixty yes/no descriptions with separate forms for 0-18 months, 18-36 months and 3-6 years. Can be mailed to families, completed in waiting rooms, administered by interview or by direct elicitation.	A single cutoff tied to 1.5 standard deviations below the mean	Sensitivity[1] was 75 percent or greater across studies and specificity[2] was 70 percent	About 10 minutes (if interview needed)
Parents' Evaluations of Developmental Status (PEDS) (1997) Ellsworth & Vandemeer Press, Ltd., P.O. Box 68164, Nashville, TN 37206 Phone: 615-226-4460; fax: 615-227-0411 pedstest.com	Birth to 9 years	Ten questions eliciting parents' concerns. Can be administered in waiting rooms or by interview. Available in 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 percent to 79 percent and specificity ranged from 70 percent to 80 percent	About two minutes (if interview needed)
Pediatric Symptom Checklist Jellinek MS, Murphy JM, Robinson J. et al. Pediatric Symptom Checklist: Screening School age children for psychosocial dysfunction. Journal of Pediatrics, 1988; 112:201-209 (the test is included in the article and in the PEDS manual)	6 to 16	Thirty-five 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 percent to 95 percent; specificity in all but one study was 70 percent to 100 percent	About seven minutes (if interview needed)

[1]Sensitivity = percentage of children with disabilities identified as probably delayed by a screening test.

[2]Specificity = percentage of children without disabilities identified as probably normal by a screening test.

Tools recommended for secondary screening involving direct testing of children

Measure	Age range	Description	Scoring	Accuracy	Time frame
Brigance Screens Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 800-225-0248	21 to 90 months	Seven separate forms, one for each 12-month age range. Taps speech-language, motor, readiness, and general knowledge at younger ages and reading and math at older ages. Uses direct elicitation and observation.	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70 percent to 82 percent	10 minutes (direct testing only)

Individual education plans

TennCare, is committed to the coordination of school-based, medically necessary services. TennCare worked closely with the Department of Education (DOE) and managed care organizations (MCOs), including Wellpoint, to ensure coordination of care and the delivery of medically necessary services to TennCare-enrolled school age children. For any medically necessary service provided in the school setting, TennCare continues to require an individual education plan (IEP) with the service included and confirmation a parental consent form was obtained. Timely filing for IEP services was effective 7/1/21 and IHP 7/1/22. Timely filing is 365 days from the date of service.

We do not require schools to send eligible students' IEPs to us before paying for the covered, medically necessary services. Instead, we audit IEPs as we do with other services, which means each school must prepare and maintain updated IEPs for each eligible student and then provide any requested IEP to us upon request. At a minimum, we are required to conduct regular post-payment sample audits of IEPs and all other documentation to support the medical necessity of the school-based services reimbursed by us.

When we require a copy of an IEP, the provider must also include a copy of the appropriate parental consent and physician's order for the identified services. TennCare has updated the authorization forms, which can be found at tn.gov/tenncare/tenncare-kids/school-based-services.html. The school can coordinate with Wellpoint to arrange for services to be provided during school or outside of a school setting. Effective July 1, 2022, the IEP may be ordered by student's PCP or treating provider OR the ordering/referring PT, ST, OT, or Audiologist.

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):

1. The billable services below are performed by the school nurse and shall be ordered by the primary care provider (PCP) or the child's treating provider. In addition to the supervision required for the performing school nurse, as described in section 4a (ii) below, the school nursing program shall have a physician to clinically supervise the physician assistant or nurse

practitioner in accordance with the Tennessee Board of Nursing Rules and Regulations and T.C.A., Title 63.

2. The school nurse will meet the clinical and licensing requirements, as required by the Tennessee Department of Health, as well as the training required to perform these services in the school setting.

3. The school will maintain policies and procedures for the provision and documentation of the services listed in the table below.

4. The following are the guidelines for billing:
    a. Use 99211 with POS (Place of Service) 03 as the daily billable CPT code, to include a global fee.
        i. 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 or IHP, as applicable.
        ii. ii. Medically necessary, covered services in the IEP or IHP that are ordered by the PCP or treating provider may be reimbursed. The IEP or IHP alone does not satisfy requirements for Medicaid reimbursement. Services are performed by the school nurse, under the clinical supervision of an in-network Physician, Physician's Assistant, or Nurse Practitioner licensed through the Tennessee Department of Health. Clinical supervision does not require the continuous and constant presence of the clinical supervisor; however, the clinical supervisor must always be available for consultation or shall arrange for a substitute provider to be available. Services are performed pursuant to the student's primary care provider's (PCP) or the child's treating provider's order.
        iii. iii. The supervising 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. 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 or IHP 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.

	Billable (Y)/Non-Billable(N)
Assessment and Treatment of acute and chronic illnesses	Y
Blood glucose monitoring and testing	Y
Vital sign monitoring	N
Tracheostomy care and suctioning	Y
Colostomy care	Y
Catherization	Y
Administration of oral medication – per tube	Y
O2 saturation monitoring (pulmonary and/or cardiac disease)	Y
G-Tube feeding	Y
Wound care	Y
Nebulizer treatment	Y
Postural drainage	N
Medication administration for medically fragile students as identified in IEP or IHP	Y
Development, implementation of Individual Health Plan (IHP)	N
Evaluation of Nursing service in the Individualized Education Program (IEP)	N

As a reminder, failure to abide by the requirements and our requests may subject the school to recoupments and, potentially, other penalties.

Vaccines for Children program

The Vaccines for Children (VFC) program was established by Congress in 1993. The VFC program is an entitlement program (a right granted by law) for eligible children age 18 years and younger. VFC helps families of children who may not otherwise have access to vaccines by providing free vaccines to doctors who serve them. VFC is administered at the national level by the CDC that contracts with vaccine manufacturers to buy vaccines at reduced rates. Tennessee enrolls physicians in the VFC program who serve eligible children and provide routine immunizations. More than 600 private physicians, health department clinics, Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) participate in VFC in Tennessee. Please note that WellPoint CoverKids members are not covered under the VFC Program, the provider will need to bill the appropriate vaccine and administration code and will be paid in accordance with their provider contract.

Children from birth through 18 years of age who meet at least one of the following criteria are eligible to receive VFC services:

- TennCare eligible: A child who is eligible for Medicaid or enrolled in the TennCare program
- Uninsured: A child who has no health insurance coverage
- American Indian or Alaska Native: As defined by the Indian Health Care Improvement Act (25 U.S.C. 1603)
- Underinsured: A child who has commercial (private) health insurance, but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for noncovered vaccines only), or a child whose insurance caps vaccine coverage at a certain dollar amount. Once that coverage amount is reached, the child is categorized as underinsured. In

Tennessee, underinsured children are eligible to receive VFC services only through an FQHC, RHC or local health department.

Children whose health insurance covers the cost of vaccinations are not eligible for VFC services, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

VFC enrollment and re-enrollment is managed through the Tennessee Immunization Information System web portal, known as TennIIS. To enroll or re-enroll please go to tennesseeiis.gov/tnsiis and select the Register to use TennIIS heading and follow the instructions provided. If you have questions about the enrollment process, please contact the VFC program at VFC.Enrollment@tn.gov.

Providers interested in joining the VFC program may contact the Tennessee Immunization Program at 800-404-3006 for enrollment information or visit tennesseeiis.gov/tnsiis.

Lead toxicity screening program
All children are considered at risk and must be screened for lead poisoning. TennCare requires the use of the blood lead test when screening children for lead poisoning. Physicians should use each office visit as an opportunity for anticipatory guidance and risk assessment for lead poisoning. Appropriate laboratory tests (including lead toxicity screening appropriate for age and risk factors). All children shall receive a screening blood lead test at twelve (12) and twenty-four (24) months of age. Children between the ages of twenty-four and thirty-six (24-36) months and seventy-two (72) months of age shall receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test shall be used when screening Medicaid-eligible children. A blood lead test equal to or greater than three point five (3.5) ug/dL obtained by capillary specimen (finger stick) shall be confirmed by using a venous blood sample. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level (BLL).

Once the initial BLL screen is performed, further testing may be required. See below:

If the capillary blood lead level is ≥ 3.5 µg/dL, follow the recommended schedule for a confirmatory venous sample	
Screening test result (µg/dL)	Time to confirmation testing
5-9	3months
10-19	1 - 3 months*
20-24	1 – 3 months
25-44	2 weeks – 1 month
≥ 45	As soon as possible

*The higher the BLL on the screening test, the more urgent the need for confirmatory testing.

The child's medical record must contain a laboratory report of test results. Diagnosis, treatment, education, and follow-up should also be documented in the medical record.

Wellpoint is required to track and follow up with members that have an elevated BLL (blood lead result with a level equal to or higher than 3.5 µg/dL (or the most current level of concern for blood lead prescribed by CDC). Providers should complete the *Elevated Blood Lead Level* form located in

Appendix A and fax it to the designated number within one week of receipt of the test results from the laboratory.

TennCare Kids visits reminder program
Wellpoint has a minimum of six outreach contacts per member per calendar year in which Wellpoint provides information about TennCare Kids to members. The minimum outreach contacts include one member handbook, four quarterly member newsletters and one reminder notice issued before a screening is due. The reminder notice will include an offer of transportation and scheduling assistance.

Wellpoint has a mechanism for systematically notifying families when TennCare Kids screens are due and mails the family a postcard reminder 45-90 days prior to the due date for screening.

Wellpoint has a process in place to follow up with members who do not get their screenings on a timely basis. This process includes provisions for documenting all outreach attempts and maintaining records of efforts made to reach out to members who have missed screening appointments or who have failed to receive regular check-ups. Wellpoint will make at least two outreach attempts in excess of the six outreach attempts to get the member in for a screening. The efforts are in different forms. The member receives a monthly text message as well as a 90-day overdue postcard reminder.

Wellpoint will determine if a member who is eligible for TennCare Kids has used no services within a year and will make two reasonable attempts to renotify such members about TennCare Kids. Wellpoint sends a one-year overdue text message, interactive voice response (IVR) call reminder, and letter which all encourage members to schedule a well-child exam with their PCP.

Local health departments
The provider agreement with a local health department must meet the minimum requirements and must also specify for the purpose of TennCare Kids screening services that:

- The local health department agrees to submit encounter data timely to Wellpoint.
- Wellpoint agrees to timely process claims for services.
- The local health department may terminate the agreement for cause with 30 days advance notice.
- Wellpoint agrees precertification will not be required for the provision of TennCare Kids screening services.

Wellpoint will reimburse contracted local health departments for TennCare Kids screenings to members under age 21 at no less than the following rates, unless specified otherwise by TennCare. Although the codes include preventive visits for individuals 21 and older, this section only requires Wellpoint to pay local health departments for the specified visits for members under age 21.

Preventive visits	85 percent of 2001 Medicare
99381 New pt. Up to 1 year	$80.33
99382 New pt. 1-4 years	$88.06

Preventive visits	85 percent of 2001 Medicare
99383 New pt. 5-11 years	$86.60
99384 New pt. 12-17 years	$95.39
99385 New pt. 18-39 years	$93.93
99391 Estab. pt. Up to 1 year	$63.04
99392 Estab. pt. 1-4 years	$71.55
99393 Estab. pt. 5-11 years	$70.96
99394 Estab. pt. 12-17 years	$79.57
99395 Estab. pt. 18-39 years	$78.99

TennCare may conduct an audit of the Wellpoint reimbursement methodology and related processes on an annual basis to verify compliance with this requirement. In addition, the local health department may initiate the independent review procedure at any time it believes the Wellpoint payment is less than the required minimum reimbursement rate.

10. BEHAVIORAL HEALTH SERVICES

Behavioral health services

Wellpoint provides behavioral health services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by TennCare. This includes mental health services such as psychiatric inpatient hospital services, 24-hour psychiatric residential treatment services, outpatient mental health services, intensive community based treatment, Tennessee Health Link (THL), psychiatric rehabilitation services and behavioral health crisis services. All behavioral health services referenced in this area are in accordance with TennCare's Contractor Risk Agreement.

Wellpoint also provides substance use disorder treatment through inpatient, residential and outpatient services. Detoxification services can be rendered as part of inpatient, residential or outpatient services as clinically appropriate. All member detoxifications are supervised by Tennessee licensed physicians with a minimum daily re-evaluation by a physician or registered nurse.

Providers are required to inform children and adolescents for whom residential treatment is being considered, their parent(s) or legally appointed guardian, and adults for whom voluntary inpatient treatment is being considered of:

- All of their options for residential and/or inpatient placement.
- Alternatives to residential and/or inpatient treatment.
- Benefits, risks and limitations of each so that they can provide informed consent.

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications, and other forms of treatment.

Behavioral health services chart

Service[1]	Benefit limit
Psychiatric Inpatient Hospital Services (including physician services)	As medically necessary
24-hour Psychiatric Residential Treatment	Medicaid/standard eligible, age 21 and older: As medically necessary Medicaid/standard eligible, under age 21: As medically necessary
Outpatient Mental Health Services (including physician services)	As medically necessary
Inpatient, Residential and Outpatient Substance Use Disorder Benefits[2]	Medicaid/standard eligible, age 21 and older: As medically necessary Medicaid/standard eligible, under age 21: As medically necessary
Behavioral Health Intensive Community Based Treatment	As medically necessary
Psychiatric-Rehabilitation Services	As medically necessary

Service[1]	Benefit limit
Behavioral Health Crisis Services	As medically necessary
Lab and X-ray Services	As medically necessary
Nonemergency Transportation (including Nonemergency Ambulance Transportation)	Same as for physical health (see Physical Health Benefits)
Behavioral Crisis Prevention, Intervention, and Stabilization Services for Members with Intellection and Developmental Disabilities (I/DD)	Time-limited, based on the needs of each member

1 Behavioral health access standards are in the Behavioral Health Access Standards section of this manual.
2 When medically appropriate, services in a licensed substance use disorder residential treatment facility may be substituted for inpatient substance use disorder services.

Behavioral health specialized service descriptions

Behavioral Health 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. Wellpoint will ensure the provision of Behavioral Health Intensive Community Based Treatment Services to 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. Behavioral Health Intensive Community Based Treatment Services shall be rendered through a team approach, 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.

Intensive Community Based Treatment 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 visits per week for individual therapy, family therapy or 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 ICC, CTT, CCFT, and PACT treatment models as described below:

Intensive Care Coordination (ICC)
Intensive Care Coordination (ICC) is a service that facilitates care planning and coordination of services for TennCare youth, with serious emotional disturbance (SED), under the age 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.

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.

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.

Program of Assertive and Community Treatment (PACT)
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 (approximately 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. 24 hour a day availability of services
8. Engagement of individuals in treatment and recovery

Tennessee Health Link

Tennessee Health Link (THL) 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.

Health Link professionals will use care coordination and patient engagement techniques to help members manage their healthcare 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 health treatment).
- Referral to social supports (e.g., facilitating access to community supports including scheduling and follow through).

Psychiatric rehabilitation

Definition

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.

The service components 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 nonresidential 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 experience 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 and recovery
Illness management and recovery services refer to a series of weekly sessions with trained mental health practitioners for the purpose of assisting individuals in developing 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 in addition to 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 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.

Behavioral Crisis Prevention, Intervention, and Stabilization Services for Members with Intellectual and Developmental Disabilities (I/DD)
Wellpoint provides BCPI&SS according to the respective standards set by TennCare. BCPI&SS is a comprehensive, person-centered approach to the delivery of behavioral health crisis prevention, intervention and stabilization services for individual with intellectual and developmental disabilities (I/DD) who experience challenging behaviors that place themselves and others at risk of harm. The system is designed to provide a full array of necessary behavioral services and supports for individuals with I/DD and co-occurring mental health and/or behavioral disorder including behavioral health crisis prevention, intervention, stabilization and when necessary, inpatient services.

This proactive model is designed to improve quality of life by promoting behavioral crisis planning and prevention. Behavioral health crisis prevention includes person-centered assessment and planning and will require the development of an individualized crisis plan that includes linkage, coordination and collaboration with current state crisis teams.

The contracted BCPI&SS provider will be the first point of contact in crisis events for members that have been enrolled into the BCPI&SS program. The provider will assess the member for the purpose of stabilization in the individual's environment; however, should the member need further assessment for potential hospitalization, the provider will collaborate with our state crisis service teams.

Procedures for requesting psychological or neuropsychological testing
Providers are encouraged to utilize the electronic request as our preferred method of receipt. This is available at provider.wellpoint.com/tennessee-provider/resources/forms. If you prefer to paper fax, you may request psychological or neuropsychological testing, providers must complete the *Request for Authorization-Psychological Testing Authorization* form or the *Behavioral Health Neuropsychological Testing* form. All sections of the forms must be completed in full as may not be able to process incomplete requests.

The completed form should be faxed to 844-451-2827.

Providers will be notified of the disposition of the request within the time standards for completing noncurrent preservice requests.

Behavioral health access standards

Service type	Geographic access requirement	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

Service type	Geographic access requirement	Maximum time for admission/appointment
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), 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 disorder)	Transport access ≤ 90 miles travel distance and ≤ 120 minutes travel time for all child and adult members.	Within two calendar days; for detoxification — within four hours in an emergency and 24 hours for nonemergency
24-hour residential treatment services (substance use disorder)*	Not subject to geographic access standards.	Within 10 business days
Outpatient treatment services (substance use disorder)	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
Medications for Opioid Use Disorder (MOUD) treatment providers (providers treating with Buprenorphine)	Transport access ≤ 45 miles travel distance and ≤ 45 minutes travel time for at least 75% of non-dual members and ≤ 60 miles travel distance and ≤ 60 minutes travel time for ALL non-dual members	Within 10 business days
Intensive community based treatment services	Not subject to geographic access standards.	Within seven calendar days
Tennessee Health Link services	Not subject to geographic access standards	Within 30 calendar days

Service type	Geographic access requirement	Maximum time for admission/appointment
Psychiatric rehabilitation services (may include psychosocial rehabilitation , supported employment, illness management and recovery, peer recovery services, family support, and supported housing)	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 two hours for emergency situations and four hours for urgent situations
Crisis stabilization	Not subject to geographic access standards.	Within four hours of referral

*24-hour residential treatment substance use disorder services may be provided by facilities licensed by TDMHSAS as Halfway House Treatment Facilities (TDMHSAS Rule Chapter 0940-05-41), Residential Detoxification Treatment Facilities (TDMHSAS Rule Chapter 0940-05-44) or Residential Rehabilitation Treatment Facilities (TDMHSAS Rule Chapter 0940-05-45).

Coordination of behavioral health

Wellpoint network providers are required to notify a member's PCP when the member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that the behavioral health provider has secured the necessary release of information. The minimum elements to be included in such correspondence are:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see PCP if medical condition identified or need for evaluation by a medical practitioner has been determined for the enrollee (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician's name and contact information

Wellpoint puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Wellpoint model of coordinated care include:

- Ongoing communication and coordination between PCPs and specialty providers including behavioral health (mental health and substance use disorder) providers.
- Screening for co-occurring disorders including:
  - Behavioral health screening by PCPs.
  - Medical screening by behavioral health providers.
  - Screening of mental health patients for co-occurring substance use disorder disorders.
  - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders.
- Screening tools for PCPs and behavioral health providers that can be located at provider.wellpoint.com/tn.
- Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders.
- Development of individualized treatment plans for each consumer and coordinating those plans with the PCP and/or other active specialty providers.
- Case management and population health programs to support the coordination and integration of care between providers.
- Consultation for providers wishing assistance in coordinating care for consumers with co-occurring disorders through the Wellpoint Provider Services line.

Recovery and resiliency

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 disorder issues. 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. The Substance use disorder and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of TDMHSAS's desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency.

The 10 fundamental components of recovery include:

1. Self-direction: Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. Individualized and person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.

3. Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
5. Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. Strengths-based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. Peer support: Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. Respect: Community, systems and societal acceptance and appreciation of consumers including protecting their rights and eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. Responsibility: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. Hope: Recovery provides the essential and motivating message of a better future- that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process for children and youth that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families should be delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- Community based with the focus of services as well as management and decision making responsibility resting at the community level.
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The guiding principles of a system of care include:
  - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs.
  - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
  - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
  - Children should receive services that are integrated, with linkages between child serving agencies and programs and mechanisms for planning, developing and coordinating services.
  - Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
  - Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

Source: TDMHSAS

Training

Wellpoint must monitor and ensure all participating providers that deliver behavioral health services provide relevant staff with training in accordance with TDMHSAS requirements. As a contracted provider of Wellpoint, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements, which can be found on the TDMHSAS website at tn.gov/behavioral-health/for-providers.html. Additionally, Wellpoint will conduct audits to ensure compliance with training requirements.

Training topic	Staff to receive	Time frame to be provided
Consumer Rights and Responsibilities		
Consumer rights and responsibilities, including (as appropriate) such topics as consumer advocacy and	Any staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or

Training topic	Staff to receive	Time frame to be provided
alternative decision making, educational rights, declarations for mental health treatment, durable power of attorney, guardianship and conservatorships*		assessment of competency • Every three years thereafter either through retraining or assessment of competency
Cultural Competence and Diversity		
Cultural competence — recognizing any unique aspects of members; these may include language, dress, traditions, beliefs about modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and substance use disorder, concepts of status and issues of privacy and personal boundaries	Any staff member, licensed staff and those for whom a license is not required.	• Initially within the first 90 days of employment either through training or assessment of competency • Annually thereafter either through retraining or assessment of competency
Prevention/Intervention and Recovery/Resiliency Strategies		
Prevention and intervention techniques to address the management of potentially aggressive behavior	Any direct care staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through re-training or assessment of competency
Recovery and resiliency-based approaches to providing services*	Any direct care staff member, licensed staff and those for whom a license is not required	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through re-training or assessment of competency
Behavioral Health/Substance Use Disorders and Associated Medical Conditions and Care		
Etiology, treatment and diagnostic categories of mental illness; serious emotional disturbance; substance	Any direct care staff member for whom a license is not required	• Initially within the first 90 days of employment either through training or

Training topic	Staff to receive	Time frame to be provided
use and/or abuse; physical and sexual abuse; suicidal ideation; developmental disabilities and intellectual disabilities, as well as general health care practices and medical conditions that may be associated with mental illness, serious emotional disturbance, and/or substance use and/or abuse*		assessment of competency • Every three years thereafter either through retraining or assessment of competency
Research-based Practices		
Evidence-based practices identified and recognized by the Center for Mental Health Services (CMHS) such as: • Illness management and recovery skills • Supported employment • Family psychoeducation • Program of Assertive and Community Treatment (PACT) • Integrated co-occurring disorders treatment (substance use and mental illness)* Resource: mentalhealth.gov samhsa.gov	Any staff member for whom a license is required in the performance of his/her duties.	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
TDMHSAS Best Practice Guidelines – adult behavioral health services and behavioral health services for children and adolescents* Resource: tn.gov/partnersforhealth/health-options/behavioral-health.html	Any staff member for whom a license is required in the performance of his/her duties	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Legal Issues and Mandates		
Legal issues and mandates regarding mental illness, serious emotional disturbance and substance use disorder such as	Any staff member for whom a license is required in the performance of his/her duties	• Initially within the first 90 days of employment either through training or

Training topic	Staff to receive	Time frame to be provided
mandatory outpatient treatment, confidentiality and involuntary commitment.*		assessment of competency • Every three years thereafter either through retraining or assessment of competency
Psychopharmacology		
Psychopharmacology such as classes of medications, drug interactions, adverse drug reactions and medication use in pregnancy and lactation.*	Any staff member for whom a license is required in the performance of his/her duties. Persons in the following categories may be exempted: physicians, pharmacists, nurse practitioners and physician assistants	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Treatment Considerations for Children and Adolescents		
System of care values and principles for the treatment of children and adolescents that are child-centered and family-focused, community-based, culturally competent and evaluated for effectiveness in addition to wraparound supports tailored to fit the individual child and family unit Resource: tn.gov/partnersforhealth/health-options/behavioral-health.html	Any staff member for whom a license is required that works directly with children and adolescents and their families	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Age appropriate developmental principles and EPSDT requirements for children and adolescents	Any staff member for whom a license is required that works directly with service recipients age 20 and under	• Within the first 90 days of employment either through training or assessment of competency
Tennessee Health Link		
Tennessee Health Link principles, assessment for treatment planning, intervention techniques, philosophy and facilitating access to community resources*	Tennessee Health Link staff and Tennessee-certified peer support specialists, as applicable	• Initially within the first 90 days of employment either through training or assessment of competency

Training topic	Staff to receive	Time frame to be provided
		• Every three years thereafter either through retraining or assessment of competency
Crisis Services Curriculum		
Tennessee Department of Mental Health & Substance Abuse (TDMHSAS) — designated crisis services curriculum	Crisis services staff and Tennessee-certified peer support specialists as applicable	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency
Psychiatric Rehabilitation Principles		
Principles of psychiatric rehabilitation and supports, including psychosocial rehabilitation, supported housing, supported employment, peer support and illness management and recovery	Staff at psychiatric rehabilitation facilities or facilities that implement psychiatric rehabilitation programs that work directly with service recipients, as well as Tennessee-certified peer support specialists	• Initially within the first 90 days of employment either through training or assessment of competency • Every three years thereafter either through retraining or assessment of competency

* Training should be appropriate to the type of staff and the population served.

Documentation of training and/or competency should be maintained by the agency in which staff members are employed.

- Documentation may take the form of:
  - Certificates.
  - Descriptions of training PLUS sign-in sheets.
  - Letters of confirmation.

Competence will be determined by the agency. One or more of the following tools might be used as documentation:

- Posttest results
- Supervisor check-off forms

Staff members currently employed with a provider will have one year after the effective date of a provider's contract with an MCC to receive any trainings listed above that they have not already successfully completed. Required training may be obtained either through the agency/provider or through outside entities that offer continuing education unit (CEU) credits or contact hours. The agency/provider may accept comparable training completed within one year prior to employment if the employee has demonstrated competence in the area.

Member records and treatment planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

1. Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
2. For members in the priority population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:

- A psychiatric assessment which includes:
  - Description of the presenting problem.
  - Psychiatric history and history of the member's response to crisis situations.
  - Psychiatric symptoms.
  - Diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM).
  - Mental status exam.
  - History of alcohol and substance use.
- A medical assessment that includes:
  - Screening for medical problems.
  - Medical history.
  - Present medications.
  - Medication history.
- A substance use assessment that includes frequently used over-the-counter medications, alcohol and other drugs and history of prior alcohol and substance use treatment episodes. The history should reflect impact of substance use in the domains of the community functioning assessment.
- A community functioning assessment or an assessment of the member's functioning in the following domains:
  - Living arrangements, daily activities (vocational/educational)
  - Social support
  - Financial

  - Leisure/recreational
  - Physical health
  - Emotional/behavioral health

- An assessment of the member's strengths, current life status, personal goals and needs.

3. An individualized treatment plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services for 30 calendar days or longer.

- The treatment plan must be completed within the first 30 calendar days of admission to behavioral health services and updated every six months, or more frequently as clinically necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- Provide documentation that the member and, as appropriate, his or her family members or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- 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 that are being provided to the member.
- The treatment plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified
  - Measurable objectives to address the members' goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - The duration and intensity of treatment shall promote the recovery and resilience of members and shall be documented in the treatment plans.
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis

4. Progress notes are written to document status related to goals and objectives indicated on the treatment plans.
5. Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
6. A brief discharge summary* must be completed within seven calendar days following discharge from services or death.
7. Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.

Note: In the event that there is an active, program-specific Program Description or comparable document indicating more specificity on the above documentation requirements, defer to the program-specific expectations.

*Wellpoint makes available Discharge Summary templates for Inpatient, Outpatient, and Supported Housing service levels. These are located on our Wellpoint TN Provider Website and can be found here: Behavioral health | Wellpoint Tennessee, Inc. (under Behavioral Health Forms)

Behavioral health supervision for unlicensed clinicians and qualified graduate students

Wellpoint expects ongoing supervision is provided by mental health/substance use disorder facilities/CMHC providers who employ unlicensed clinical staff and/or qualified graduate students to complete clinical activities (such as clinical assessments and psychotherapy). The facility should ensure all unlicensed clinicians and/or qualified graduate students are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the unlicensed clinician and/or qualified graduate student to review the treatment and services provided to members.

Under the supervision of an independently licensed clinician, unlicensed master's level clinicians and/or qualified graduate students who render behavioral health professional services must 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.

- 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.

Crisis services

Definition

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 24 hours a day, 7 days a week. Crisis services include 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 pre-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 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 department, telehealth is the preferred service delivery method for the crisis response service.
- After determining there is no immediate harm, ask the person if they can come to the closest walk-in center.
- If a Mandatory prescreening agent (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.

Mandatory prescreening agent

Tennessee law requires a face-to-face evaluation, known as prescreening, of each member in crisis to assess eligibility for emergency involuntary admission to a Regional Mental Health Institute (RMHI) and to determine whether all available, less drastic, alternative services and supports are unsuitable to meet the member's needs. An MPA is required to complete one of the certificates of need (CONs) prior to an emergency admission to a RMHI. Private hospitals that have been approved by TDMHSAS and accept the authority of an MPA may also accept CONs from an MPA for emergency involuntary admissions.

Behavioral health crisis respite

All behavioral health crisis service providers must provide access to crisis respite 24 hours a day, 7 days a week for all members meeting guidelines for this level of treatment including:

- Diagnosed or suspected mental illness.
- Mental status exam reveals no immediate intent to harm self or others.
- Respite is deemed a safe level of treatment.
- Respite would be an appropriate and beneficial level of treatment.

Behavioral health crisis respite services are intended to provide immediate shelter to those members with emotional/behavioral problems who are in need of emergency respite. These services involve short-term respite with overnight capacity for room and board, while meeting the member's crisis need(s). Trained crisis respite staff members typically provide crisis respite. However, others who are deemed appropriate by crisis staff members may render respite services. For children/youth, authorization must be given for the use of crisis respite services by the parent, legal guardian, legal custodian, legal caretaker or court with appropriate jurisdiction.

If a behavioral health crisis respite service provider is unable to obtain a current treatment plan, then the behavioral health crisis respite service provider will complete a respite plan that is developed and agreed upon in writing by the member, respite staff and family/care givers/support system as applicable. The plan should include actions to attain stabilization or alleviation of the crisis situation. Crisis respite must be rendered in a community location approved by the managed care company or a site licensed by TDMHSAS that can be facility-based, home-based or hospital-based in nature, depending on the need and availability.

Behavioral health crisis respite services will continue to be utilized by those members that continue to be serviced on the DDA (Department of Disability and Aging) waiver to provide immediate shelter to I/DD members with emotional/behavioral problems who are in need of emergency respite in the event that the member cannot be stabilized in the current living environment. These services are delivered by contracted providers in community locations approved by the health plan.

Facility-Based Crisis Respite Services
Crisis respite services that use a placement in a facility with direct care from trained crisis respite staff in direct response to a consumer's acuity level based on the assessment of risk.

Home-Based Crisis Respite Services
Crisis respite services that use a placement in a home approved by the behavioral health crisis services provider with direct care from trained crisis respite staff or family members/significant others in direct response to a consumer's acuity level based on the assessment of risk.

Hospital-Based Crisis Respite Services
Crisis respite services that use hospital emergency rooms or other acute psychiatric services based on the assessment of risk to the member and/or the need for a medically supervised setting.

Crisis stabilization services
Crisis stabilization services are short-term supervised care services, accessed to prevent further increase in symptoms of a behavioral health illness or to prevent acute hospitalization. Crisis stabilization services are more intensive than regular crisis respite services in that they require more secure environments, highly trained staff and have typically longer stays. For adults, these services are provided in Crisis Stabilization Units licensed by TDMHSAS. Crisis stabilization services should include availability and utilization of the following types of services on a short-term basis as appropriate:

- Individual and/or family counseling/support
- Medication management/administration
- Stress management counseling
- Individualized treatment plan development that empowers the consumer
- Mental illness/substance use disorder awareness/education
- Identification and development of natural support systems

If a crisis stabilization service provider is not able to obtain a current treatment plan, then the crisis stabilization services provider shall complete a crisis stabilization plan that is developed and agreed upon in writing by the individual, staff and the individual's significant others if appropriate. This plan identifies services and assistance needed to achieve stabilization as well as the components needed for discharge or transition to a lower level of care. Discharge/transition plans are to address what criteria are needed for the individual to move safely to a less restrictive level of care. This plan may also detail what is needed to move an individual to a higher level of care if it is deemed appropriate.

Follow-up services
Follow-up services can be telephone call(s) or face-to-face assessment(s) between crisis staff and the member following crisis intervention, respite or stabilization to ensure the safety of the member until treatment is scheduled or treatment begins and/or the crisis is alleviated and/or stabilized. Follow-up services can include crisis services contacting the member only one time or can include several contacts a day for several days as deemed appropriate by crisis staff.

A follow-up contact with the member must be made within 12 hours of an MPA face-to-face assessment or anytime a physician or psychologist conducts a face-to-face assessment because an MPA was not available within two hours when it is determined that psychiatric inpatient criteria is not met. A follow-up contact with the member must be made within 24 hours of a crisis specialist face-to-face assessment that does not involve an MPA or a physician or psychologist acting in place of an MPA when it is determined that psychiatric inpatient criteria is not met. Should a crisis specialist's face-to-face assessment result in psychiatric inpatient criteria being met, contact with the inpatient facility to verify admission must be completed within 24 hours.

Adverse occurrences
Adverse occurrence reports must be reported by each network provider to all appropriate agencies and Wellpoint as required by licensure and state and federal laws within the specified time frames required immediately following the event.

The applicable providers required to report are:
- Inpatient psychiatric hospitals.
- Psychiatric residential treatment centers.
- Substance use disorder inpatient psychiatric hospitals.
- Substance use disorder residential treatment centers.
- Crisis stabilization units.
- Supported housing.

The reportable categories of incidents are:
- Suicide death.
- Nonsuicide death.
- Death, cause unknown.

- Homicide.
- Homicide attempt with significant medical intervention.*
- Suicide attempt with significant medical intervention.*
- Accidental injury with significant medical intervention.*
- Use of restraints or seclusion (physical, chemical or mechanical) requiring significant medical intervention.*
- Treatment complications (medical errors and adverse medical reactions) requiring significant medical intervention.*
- Elopement (specific to inpatient and residential services only, as related to minors or involuntary admits for adults).
- Allegation of physical, sexual or verbal abuse or neglect, including peer-to-peer
- Medical emergency (e.g., heart attack, medically unstable, etc.).

* For purposes of behavioral health adverse occurrences, significant medical intervention is defined as requiring an ER visit or inpatient hospital stay.

Adverse occurrences should be reported within 24 hours of detection or notification. A form for reporting these incidents is included in the Forms section of this manual and on our provider website. Providers should complete all portions of the form and fax to 877-423-9976. Any questions concerning this form may be directed to the Quality Management department at 615-316-2400.

11. MEMBER ENROLLMENT

Member enrollment process

The Division of TennCare will process all member enrollments. Enrollment will begin at 12:01 a.m. on the effective date of enrollment with Wellpoint and will end at midnight on the date that the enrollee is disenrolled from Wellpoint. After becoming eligible for TennCare and enrolling in Wellpoint (whether the result of selection by the enrollee or assignment by TennCare), enrollees will have one opportunity, anytime during the 90-day period immediately following the effective date of enrollment with Wellpoint or the date TennCare sends the member notice of enrollment in Wellpoint, whichever is later, to request to change MCOs. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select during this 90-day period.

TennCare will provide an opportunity for members to change MCOs (excluding TennCare Select) every 12 months. Children eligible for TennCare as a result of being eligible for SSI may request to enroll in another MCO or re-enroll with TennCare Select every 12 months.

Members who do not select another MCO will be deemed to have chosen to remain with their current MCO.

A member may request disenrollment or be disenrolled if:

- The member chooses another MCO during the 90-day change period after the member's enrollment is effective.
- The member chooses another MCO during the annual choice period.
- An appeal by the member to change MCOs based on hardship criteria (pursuant to TennCare rules and regulations) is decided by TennCare in favor of the member.
- The member is assigned incorrectly to the MCO by TennCare and requests enrollment in another MCO.
- The member moves outside the Wellpoint service area.
- During the appeal process, if TennCare determines it is in the best interest of the enrollee and TennCare.
- The member loses eligibility for TennCare.
- TennCare grants the member the right to terminate enrollment, and the member exercises that right.
- Wellpoint no longer participates in TennCare.

Unknown member assignment and retro-enrolled members

Because individuals can be retroactively eligible for TennCare, and the effective date of initial enrollment in an MCO is the effective date of eligibility, the effective date of enrollment may occur prior to the MCO or the individual being notified and enrollment of individuals in an MCO may occur

without prior notice to the MCO or enrollee. The Tennessee Contractor Risk Agreement (CRA) language sets out the CRA provisions for payment of these claims.

Wellpoint will review claims for retro-enrolled/retro-assigned members ordinarily requiring authorization for medical necessity prior to payment. Claims payment determinations/adjudication approval overriding authorization requirements will only be given after the medical necessity review of submitted medical records.

Effective October 1, 2020, if you submit a claim for a retro-enrolled member (including sick newborns) for services that would have required prior authorization, you will need to submit medical records with the claim. Please do not request prior authorization for services already rendered. Claims submitted without medical records will be denied for medical record submission. If you receive a claim denial, you may file a first-level claims payment dispute to include the medical records within 365 days from the initial denial of the claim. Wellpoint will review the records received and issue a medical necessity determination on the claim.

Timely filing for claims submitted for our retro-enrolled/retro-assigned members will not change. A member claim must be filed prior to 120 days from the date the MCO is notified of the enrollment by the State. Timely filing overrides will not be given if the claim is submitted after the 120-day timely filing limit from the MCO's receipt date of the eligibility file from the State.

Newborn enrollment process

TennCare-eligible newborns and their mothers, to the extent that the mother is eligible for TennCare, should be enrolled in the same MCO with the exception of newborns who are SSI eligible at birth. Newborns who are SSI eligible at birth will be assigned to TennCare Select, but the parent or guardian may choose to opt out of TennCare Select and choose Wellpoint as the baby's MCO.

Member eligibility listing

The PCP may access a listing of his or her panel of assigned members online at provider.wellpoint.com/tn. If a member calls to change his or her PCP, the change will be effective as of the date of the request, unless the member has been seen by his or her assigned PCP on the same date of the request. If this is the case, the effective date will be the next business day. The PCP should verify that each Wellpoint member receiving treatment in his or her office is on the PCP's membership listing. For questions regarding a member's eligibility, providers may access provider.wellpoint.com/tn or call the automated provider inquiry line at 833-731-2154.

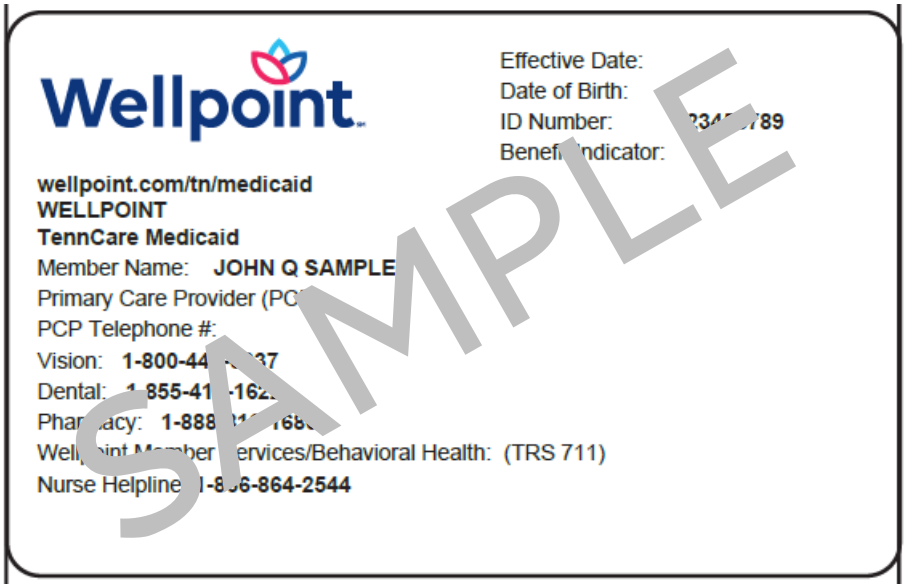
Member identification cards

Each Wellpoint member will be provided with an identification card, which identifies the member as a participant in the TennCare program within 30 calendar days of notification of enrollment into Wellpoint or prior to the member's enrollment effective date. The identification card will include:

- The member's identification number.
- The member's name (first and last name and middle initial).
- The member's date of birth.

- The member's enrollment effective date.
- Phone numbers for information and/or authorizations including for behavioral health services.
- Descriptions of procedures to be followed for emergency or special services.
- Copay responsibility.
- The *HIPAA* adopted identifier.
- The words Medicaid or Standard based on eligibility.
- The appropriate Wellpoint address and telephone number.
- The PCP's name.

Wellpoint member identification card sample:



12. MEMBER MANAGEMENT SUPPORT

Welcome call

As part of our member management strategy, Wellpoint offers a welcome call to new members. Additionally, Member Services representatives offer to assist the member with any current needs such as scheduling an initial checkup and transportation to the appointment if needed.

Appointment scheduling

Wellpoint, through its participating providers, ensures that members have access to primary care services for routine, urgent and emergency services as well as to specialty care services for chronic and complex care. Providers will respond to a Wellpoint member's needs and requests in a timely manner. The PCP must schedule members for appointments using the guidelines outlined in the section of this manual entitled PCP Access and Availability.

Member missed appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Wellpoint requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling the appointment. The contact must be by telephone and should be designed to educate the member about the importance of keeping appointments and to encourage the member to reschedule the appointment.

Members who frequently cancel or fail to show up for an appointment without rescheduling the appointment may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at 833-731-2154 to address the situation. Wellpoint staff will contact the member and provide more extensive education and/or case management as appropriate. The goal of Wellpoint is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP. Providers may not bill members for missed appointments.

Nonadherent members

Wellpoint recognizes that providers may need help in managing nonadherent members. If you have an issue with a member regarding behavior, treatment cooperation and/or completion of treatment and/or making or appearing for appointments, please contact our Provider Services at 833-731-2154.

A member/provider services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report to you the outcome of any counseling efforts.

Member dismissal

The provider may determine that the member should be dismissed from his or her panel. The provider must send a certified letter to the member or head of household indicating that the member must select a new PCP within 30 days of the notice. The provider must continue to provide

care until the effective date for assignment to the new PCP. A copy of the letter must be mailed to the National Customer Care department at:

National Customer Care
Wellpoint
22 Century Boulevard, Suite 310
Nashville, TN 37214

24-hour Nurse HelpLine

The 24-hour Nurse HelpLine provides triage services and helps direct members to appropriate levels of care. The 24-hour Nurse HelpLine telephone number is 833-731-2153 (TTY 711) and is listed on the member's ID card. This ensures that members have an additional avenue of access to health care information when needed. Available 24 hours a day, 7 days a week, the Nurse HelpLine is a service designed to support the provider by offering information and education to members after normal physician practice hours about medical conditions, health care and prevention. The 24-hour Nurse HelpLine includes:

- Information based upon nationally recognized and accepted guidelines.
- Free translation services for 170 different languages and for members with difficulty hearing, use of a TDD line.
- Education for members about appropriate alternatives for handling nonemergent medical conditions.

A member's assessment report will be faxed to the member's provider office within 24 hours of receipt of a call to the 24-hour Nurse HelpLine.

Health promotion

Wellpoint strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers that are contracted with Wellpoint.

Wellpoint manages projects that offer our members education and information regarding their health. Ongoing projects include:

- A quarterly member newsletter.
- The creation and distribution of Ameritips, a health education tool used to inform members of health promotion issues and topics.
- The development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards).
- Partnering with providers to focused efforts promoting the patient/physician relationship and closure of care gaps.
- Providing various member and provider incentives aimed at improving clinical outcomes.

- Relationship development with community-based organizations to enhance opportunities for members.

Population Health

Our Population Health program is part of an integrated and comprehensive Healthcare Management Services model that is based upon risk stratification of the entire population. The Population Health Model touches members across the entire care continuum, promoting healthy behaviors and disease self-management as well as providing care coordination and intense care management as needed and supported by evidence-based medicine and national best practices.

The Population Health model evaluates the entire member population and identify members for specific cohorts, according to risk rather than disease specific categories. Wellpoint utilizes a combination of predictive modeling utilizing claims data, CSMD data, pharmacy data, and laboratory results, supplemented by referrals, UM data, and/ or health risk assessment results to stratify the member population into cohorts. Wellpoint re-stratifies the entire member population monthly. Activities, interventions, and education objectives appropriate for members will vary for each cohort, with increasing engagement and intensity as level of risk increases. The Population Health risk level programs ranging from no risk to high risk are as follows:

No Risk (Wellness/Prevention)
Members identified as eligible for our Wellness program receive quarterly member newsletters that address specific topics focused on health promotion and disease prevention.

Low Risk Case Management
Members will be put into cohorts designed to manage members with rising risks and chronic care needs.
The goal of the cohorts is to improve the quality of life, health status and utilization of services of members with multiple chronic conditions by providing intense self-management education and support.

Low-Risk Maternity and High-Risk Maternity

Taking Care of Baby and Me® is a proactive care management program for all perinatal members and their newborns. We use several resources to identify pregnancies as early as possible. Sources of identification include, state enrollment files, claims data, and hospital census reports as well as provider and member self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care management services to mitigate risk.

Experienced care managers work with members and providers to establish a care plan for our highest risk pregnant members. They may also collaborate with community partners to facilitate connecting members to local and national agencies who can assist with services and support.

When it comes to pregnancy, we are committed to healthy outcomes for our members and their babies. That is why we encourage all of our pregnant and postpartum members to take part in our Taking Care of Baby and Me program, a comprehensive program which offers:

- Individualized, one-on-one complex care management support for members with the highest risk
- Care coordination for members who may need just a little extra support
- Digital perinatal educational tools
- Information on community resources
- Incentives to encourage members to keep up with checkups
- Proactive care coordination and complex care management support for parents of infants that are admitted to the neonatal intensive care unit (NICU).

As part of the Taking Care of Baby and Me® program, perinatal members have access to a digital perinatal offering. This digital offering is available by smartphone app and provides pregnant and postpartum members with timely, proactive, and culturally appropriate education. Once members are identified as being pregnant, they will receive an invitation to access this program by downloading the app. After the app is installed and the member registers, they are asked to complete a pregnancy screener. The answers provided in the screener allows us to assess their pregnancy risk.

After the risk assessment has been completed, the app delivers gestational-age appropriate education directly to the member. This digital offering does not replace the high-touch, individual care management approach for our highest risk pregnant members; however, it does serve as a supplemental tool to extend our health education outreach. The goal of the expanded outreach is to ensure maternity education is available to all perinatal members and help Wellpoint to identify members who experience a change in risk acuity throughout the perinatal period.

We request notification of pregnancy at the first prenatal visit and notification of delivery following birth. Please complete the Maternity Care Management Notification Form and fax it to Wellpoint at 866-495-5788. You may choose to complete the notification of delivery in Availity Essentials or fax the completed form to Wellpoint at 800-964-3627.

We also ask that providers complete the Maternity Application in Availity Essentials during the initial E&B request performed on a pregnant member. The information obtained during this process supports our effort to identify pregnancies as early as possible so that we may notify eligible members of various perinatal resources, including the care management program. The steps to complete the Maternity Application are detailed below:

Perform an Eligibility and Benefits (E&B) request on the desired member.

- Choose one of the following benefit service types: maternity, obstetrical, gynecological, or obstetrical/gynecological.
- If the appropriate conditions apply for payer, user, member and service type, the maternity question screen will display. Conditions include:
    - Member is female
    - Member is 45 years of age or under
    - Member 15 years of age or over
- If member is not pregnant, select no and hit submit to continue to the E&B response screen.
- If member is pregnant, select yes and hit submit. You will be prompted to enter additional dates if known:
    - Estimated Due Date
    - First Prenatal Appointment Date
- When YES is selected, maternity data entered is saved for this member.

- After submitting your answer, the E&B response screen will display.

We encourage healthcare providers to share information about this program and the digital perinatal app with members. Members may access information about the products that are available by visiting the Wellpoint member website.

For more information about the Taking Care of Baby and Me program or the digital app, reach out to Provider Services at 833-731-2154, or refer to our website at https://www.provider.wellpoint.com/tennessee-provider/patient-care/maternal-child-services.

Neonatal Intensive Care Unit (NICU) Care Management (H2)
If a baby is born premature or with a serious health condition, they may be admitted to the NICU. We believe the more parents know, the better they will be able to care for their infant. To support them, we have a NICU Care Management program.

We extend our support by helping parents to prepare themselves and their homes for when baby is released from the hospital. After baby is home, our care managers continue to provide education and assistance in improving baby's health, preventing unnecessary hospital readmissions, and guiding parents to community resources if needed.

The NICU can be a stressful place, bringing unique challenges and concerns that parents may have never imagined. The anxiety and stress related to having a baby in the NICU can potentially lead to symptoms of post-traumatic stress disorder (PTSD) in parents and caregivers. To reduce the impact of PTSD among our members, we assist by:

- Helping parents engage with hospital-based support programs
- Facilitating parent screenings for potential PTSD
- Connecting parents with behavioral health program resources and community support as needed
- Actively asking for their feedback on the provided resources and how an increased awareness of PTSD has helped

For more information about the NICU care management program or the digital app, reach out to Provider Services at 833-731-2154, or refer to our website at https://www.provider.wellpoint.com/tennessee-provider/patient-care/maternal-child-services.

Care coordination

Members from any Population Health program are eligible at any time for care coordination enrollment. Members may benefit from care coordination services when they have short-term, immediate, targeted needs and do not require complex case management services. Additionally, members who have more intensive needs and are appropriate for complex case management but refuse those services may be appropriate for care coordination services. Members engaged in care coordination may receive various interventions including:

- Assistance with resources such as transportation and pharmacy benefits.
- Arranging PCP appointments.
- Telephonic contact for coaching.
- Mailings of disease-specific educational materials.

- Information regarding Wellpoint On Call (24-hour Nurse HelpLine).

Enhanced Care Coordination
Care Coordination for members with an identified unmet social need.

High-Risk Case Management

We administer an initial health risk assessment to members who are identified for and agree to enroll in the Complex Case Management program. The case manager assesses the member's total health care needs in a holistic manner including physical, behavioral, functional, cognitive, and social factors. As part of the assessment process, the case manager completes a gap analysis to determine health care needs and prioritize goals. Upon identification of health care needs, the case manager will work with the member, his or her health care providers, and the member's family and caregivers to develop interventions to support the achievement of the identified health goals. Interventions may include:

- Health education.
- Interpretation of benefits.
- Community resource referrals.
- Post-discharge service authorizations and member outreach (e.g., DME, home health services and coordination of physician appointments).
- Service coordination.
- Medication reconciliation review.
- Assistance in developing a self-management plan.
- Community-based services (e.g., home or hospital visits).
- Provider-based intensive case management (behavioral health).
- Special needs program interventions.
- Ongoing assessment of barriers to meeting goals or complying with the care plan.
- Interventions to address those barriers.

Program features:

- Proactive population identification processes
- Program content is based on evidence-based national practice guidelines
- Collaborative practice models to include physician and support service providers in treatment planning for members
- Continuous patient self-management education
- Ongoing communication with primary and ancillary providers regarding patient status

- Nine of our Population Health Condition Care programs are National Committee for Quality Assurance accredited and incorporate outreach, education, care coordination and follow-up to improve treatment compliance and enhance self-care.

Additionally, all Wellpoint programs are based on nationally approved Clinical Practice Guidelines located at provider.wellpoint.com/tn. Under *Resources*, select Policies, Guidelines, and Manuals. A copy of the guidelines can be printed from the website or upon request by contacting Provider Services at 833-731-2154.

Who is eligible?
All Wellpoint members are stratified in the Population Health Program. Members may choose to opt out of the program. Members are stratified within the Population Health program based on overall clinical risk, which considers their age, gender, diagnosis history, service utilization history and self-reported risk factors. We derive this information through continuous case finding efforts, welcome calls, and referrals from both internal and external sources.

The Population Health services are provided whether members are well, have an ongoing health problem or have a health episode. Population Health's Condition Care services are available to members depending on individual health risks and need for the service and may include but are not limited to the following:

- Asthma
- Hypertension
- Bipolar disorder
- Major depressive disorder - Adult
- Major depressive disorder – Children and adolescent
- Chronic obstructive pulmonary disease (COPD)
- Obesity/weight management
- Congestive heart failure (CHF)
- Schizophrenia
- Coronary artery disease (CAD)
- Smoking cessation
- Diabetes
- Substance use disorder
- HIV/AIDS

You can refer patients who can benefit from additional education and care management support. Our case managers will collaborate with you to obtain your input in the development of care plans. Members identified for participation in any of the cohorts are assessed and stratified based on the severity of their disease. Once enrolled in a cohort, they are provided with continuous education on self-management concepts, which include primary prevention, coaching related by healthy behaviors and compliance/monitoring, as well as case/care management for high-risk members. Providers are given telephonic and/or written updates regarding patient status and progress.

Provider rights and responsibilities
The provider has the right to:

- Obtain information about us on our programs and services, our staff and their qualifications, and any contractual relationships.
- Decline participation in our Population Health program and services for his or her patients.

- Be informed of how we coordinate our Population Health-related interventions with your patient treatment plans.
- Know how to contact the person responsible for managing and communicating with the provider's patients.
- Be supported by the organization to make decisions interactively with patients regarding their health care.
- Receive courteous and respectful treatment from our staff.
- Communicate complaints about Population Health programs as outlined in our Provider Complaint and Grievance Procedure.

Hours of operation
Our case managers are registered nurses who are available from 8:30 a.m.- 5:30 p.m. local time, Monday-Friday. We also have confidential voicemail available 24 hours a day. The 24-hour Nurse Helpline is available for our members 24 hours a day, 7 days a week at 833-731-2153 (TTY 711).

Contact information
Please call 833-731-2154 to reach a case manager. Find more information about Population Health's Condition Care by visiting provider.wellpoint.com/tn. Members can get information about our Population Health's Condition Care program by visiting wellpoint.com/tn/medicaid/member-materials or calling 888-830-4300.

Submitting provider demographic data requests and roster submissions through roster automation
Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers.* Going forward, the PDM application is now the preferred intake tool for care providers to submit demographic change requests, including submitting roster uploads. If preferred, Providers may continue to utilize the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups for available provider types.

Within the PDM application, Providers have the choice and flexibility to request data updates via the standard PDM experience or by submitting a spreadsheet via a roster upload.

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel document. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation today.**

The resources for this process are listed below and available on our website. Visit providers.wellpoint.com/TN, then under For Providers, select Forms and Guides. The Roster Automation Rules of Engagement and Roster Automation Standard Template appear under the Digital Tools category:

- Roster Automation Rules of Engagement: Is a reference document, available to ensure error-free submissions, driving accurate and more timely updates through automation.

- Roster Automation Standard Template: Use this template to submit your information. More detailed instructions on formatting and submission requirements can also be found on the first tab of the Roster Automation Standard Template (*User Reference Guide*).
- Upload your completed roster via the Availity PDM application.

Accessing PDM Application:
Log onto Availity.com and select My Providers > Provider Data Management to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select Upload Rosters (see screen shot below) and follow the prompts.

Availity Administrators will automatically be granted access to PDM. Additional staff may be given access to Provider Data Management by an administrator. To find your administrator, go to My Account Dashboard > My Account > Organization(s) > Administrator Information.

* Exclusions: Any specific state mandates or requirements for provider demographic updates
** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

WIC program

WIC provides specific nutritious supplemental food and nutrition education at no cost to low-income pregnant, postpartum, breastfeeding women, infants, and children up to their 5th birthday. They must meet income guidelines, a state residency requirement, and be individually determined to be at nutritional risk by a health professional such as a physician, nutritionist, or nurse. WIC serves as an adjunct to good health care. Many TennCare families are WIC recipients. More information about the WIC program is available at tn.gov/health/health-program-areas/fhw/wic.html.

Provider disenrollment process

Providers may cease participating with Wellpoint for either mandatory or voluntary reasons.

Mandatory disenrollment occurs when a provider becomes unavailable due to immediate, unforeseen reasons. An example of this could include loss of license. In the case of a mandatory disenrollment of a PCP, members will be auto-assigned to another PCP to ensure that members have continuous access to the TennCare covered services, as appropriate. Wellpoint will notify members of any termination for PCPs or other providers from whom they receive ongoing care.

Wellpoint will provide notice to affected members when a provider disenrolls for voluntary reasons, such as retirement. Providers must provide written notice to Wellpoint within the time frames

specified in their participating provider agreement with Wellpoint. Members linked to a PCP who has disenrolled for voluntary reasons will be notified to self-select a new PCP.

Wellpoint is responsible for submitting notification of all provider disenrollments to the Division of TennCare.

Reporting changes in address and/or practice status

Any status changes are to be reported to:

Provider Relations Department
Wellpoint
22 Century Blvd., Suite 310
Nashville, TN 37214

13. MEMBER RIGHTS AND RESPONSIBILITIES

Member rights and responsibilities

Members have rights and responsibilities when participating with an MCO. Our Member Services representatives are advocates for our members. The following lists the rights and responsibilities of members:

Members have the right to:

- Be treated with respect with due consideration for dignity and privacy.
- Participate in Wellpoint without being discriminated against on the basis of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classification protected under applicable federal and state laws.
- Privacy during a visit with their doctor.
- Talk about their medical record with their PCP and ask for a summary of that record and request to amend or correct the record as appropriate.
- Be properly educated about and helped to understand their illnesses and the available health care options.
- Have a candid discussion with their provider of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Participate in decision-making about the health care services they receive.
- Refuse health care (to the extent of the law) and understand the consequences of their refusal.
- Be free from any form of restraint or seclusion as a means of coercion, discipline, inconvenience or retaliation as specified in other federal regulations on the use of restraints and seclusion.
- Decide ahead of time the kinds of care they want if they become sick, injured or seriously ill by executing an advance directive.
- Expect that their records (including medical and personal information) and communications will be treated confidentially.
- If under age 18 and married, pregnant or have a child, be able to make decisions about themselves and/or their child's health care.
- Choose their PCP from the Wellpoint network of providers.
- Have information about Wellpoint, its services, providers and member rights and responsibilities.
- Receive information on the Notice of Privacy Practices as required by *HIPAA*.
- Get a current member handbook and a provider referral directory.
- Choose any Wellpoint network specialist after getting a referral from their PCPs; some services do not require a referral, such as family planning.
- Be referred to health care providers for ongoing treatment of chronic disabilities.

- Have access to their PCPs or backups 24 hours a day, 365 days a year for urgent or emergency care.
- Get care right away from any hospital when their symptoms meet the definition of an emergency medical condition.
- In certain circumstances, get post-stabilization services following an emergency medical condition.
- Call the 24-hour Nurse HelpLine toll free 24 hours a day, 7 days a week at the following numbers:
  - English: 866-864-2544 (TRS 711)
  - Spanish: 866-864-2545 (TRS 711)
- Call the Wellpoint Member Services staff toll free from 7 a.m. to 5:30 p.m. Central time Monday through Friday at 833-731-2153 (TTY 711).
- Know what payment methodology Wellpoint uses with health care providers.
- File a medical appeal with TennCare.
- Freely exercise the right to file a complaint or an appeal without adversely affecting the way members are treated.
- Receive notification to present supporting documentation for their complaints.
- Continue to receive benefits pending the outcome of appeal or fair hearing under certain circumstances.
- Only be responsible for cost-sharing as defined in the cost-sharing section of this manual.
- Make recommendations regarding the organization's member rights and responsibilities policies.

Members have the responsibility to:

- Treat their doctors, their doctors' staff and Wellpoint employees with respect and dignity.
- Not be disruptive in their doctor's offices.
- Respect the rights and property of all providers.
- Cooperate with people providing health care.
- Tell their PCP and/or their treating physician about their symptoms and problems and ask questions.
- Get information and understand their health problems and consider treatments to participate in developing mutually agreed upon treatment goals before services are performed.
- Discuss anticipated problems with following their doctor's directions.
- Consider the outcome of refusing treatment recommended by a doctor.
- Help their doctor obtain medical records from their previous doctors and help their doctor complete new medical records as necessary.
- Respect the privacy of other people waiting in doctors' offices.

- Secure referrals from their PCPs, when specifically required, before going to another health care provider unless they have a medical emergency.
- Call Wellpoint to change their PCPs before seeing any new PCPs.
- Make and keep appointments and be on time; members should always call if they need to cancel appointments, change appointment times or if they will be late.
- Discuss complaints, concerns and opinions in an appropriate and courteous way.
- Tell their doctor who they want to receive their health information.
- Obtain medical services from their PCPs.
- Learn and follow the Wellpoint policies outlined in the member handbook.
- Read the member handbook to understand how Wellpoint works.
- Notify TennCare if a family member who is enrolled in Wellpoint has died.
- Notify TennCare if addresses and/or status change.
- Give TennCare proper identification when they enroll.
- Become involved in their health care and cooperate with their doctor about recommended treatment and care that they have agreed on with their doctor.
- Know the correct way to take their medications.
- Carry their Wellpoint ID card at all times and report any lost or stolen cards to Wellpoint quickly; members should contact TennCare of the Tennessee Department of Human Services if there are changes to their name, address or marital status. Members should never let anyone else use their Wellpoint ID card.
- Show their ID cards to each provider.
- Tell Wellpoint about any doctors they are currently seeing.
- Notify their PCPs as soon as possible after they receive emergency services.
- Go to the emergency room when they have an emergency.
- Report suspected fraud, waste, and abuse.

Member rights under Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 is a federal law that protects members and participants like providers from discrimination based on their race, color or national origin in programs and activities that receive federal financial assistance. If members are eligible for Medicaid, other health care or human services, he/she cannot be denied assistance because of race, color or national origin. The Office for Civil Rights in the U.S. Department of Health and Human Services (DHHS) enforces Title VI as well as other civil rights laws.

Some of the institutions or programs that may be covered by Title VI are:

- Extended care facilities.
- Mental health centers.

- Public assistance programs.
- Nursing homes.
- Adoption agencies.
- Hospitals.
- Day care centers.
- Senior citizen centers.
- Medicaid and Medicare.
- Family health centers and clinics.
- Alcohol and substance use disorder treatment centers.

Under federal and state regulations of Title VI of the Civil Rights Act of 1964 and Section 1557 of the Patient Protection and Affordable Care Act, translation or interpretation services needed to effectively communicate with a Limited English Proficiency (LEP) individual are to be provided by the entity at the level at which the request for service is received. The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to TennCare℠ and it is not permissible to charge a member for these services. The U.S. Department of Health and Human Services issued guidance on preventing discrimination against LEP individuals at: federalregister.gov/documents/2003/08/08/03-20179/guidance-to-federal-financial-assistance-recipients-regarding-title-vi-prohibition-against-national.

Providers can find more resources for effectively communicating with individuals and civil rights compliance information at TennCare's Provider Civil Rights Information webpage at: tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html

The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

- health.gov/our-work/national-health-initiatives/health-literacy
- health.gov/our-work/national-health-initiatives/health-literacy/consumer-health-content/myhealthfinder

And can also recommend resources for use when LEP services are needed at: hhs.gov/civil-rights/for-providers/index.html

Prohibited discriminatory acts

There are many forms of illegal discrimination based on a person's status or perceived characteristics like race, disability, age, or sex that frequently limit the opportunities of individuals to gain equal access to services and health care. Beneficiaries like members and participants like providers of a program receiving federal financial assistance may not, based on status protected under federal and state civil rights laws:

- Be denied services or other benefits provided as a part of health or human service programs.
- Be provided a different service or other benefit or be provided with services in a different manner from those provided to others under the program.
- Be segregated or separately treat members in any matter related to the receipt of any service, financial aid or other benefit.

For information on how to file a complaint of discrimination or to obtain information regarding civil rights in the TennCare program, you may contact:

- Wellpoint: 833-731-2153 (TTY 711)
- TennCare Office of Civil Rights Compliance
- More information about civil rights compliance, including forms, policies, and notices can be found online at: tn.gov/tenncare/members-applicants/civil-rights-compliance.html and tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html
- Phone: 615-507-6474 or for free at 855-857-1673 (TRS Dial 711)
- Email: HCFA.fairtreatment@tn.gov
- You can file a complaint online at: ocrportal.hhs.gov/ocr/portal/lobby.jsf or find more information at: at hhs.gov/ocr
  - Call: 800-368-1019 (toll free)
  - TDD: 800-537-7697

The TennCare Discrimination Complaint form in English, Arabic, and Spanish is located in Appendix A.

Member rights under the Nondiscrimination in Health Programs and Activities Final Rule

Wellpoint does not engage in, aid or perpetuate discrimination against any person on the basis of race, color, national origin, disability, age or sex in providing aid, benefits or services to beneficiaries. Wellpoint does not utilize or administer criteria having the effect of discriminatory practices on the basis of a person's status protected under the applicable federal and state civil rights laws. Wellpoint does not select site or facility locations that have the effect of excluding individuals from, denying the benefits of or subjecting them to discrimination on the basis of on the basis of a person's status protected under the applicable federal and state civil rights laws. Wellpoint provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of sex, race, color, age, religion, national origin, physical or mental disability, other protected statuses, or type of illness or condition.

Members who contact us with an allegation of discrimination are informed immediately of their right to file a grievance. This also occurs when a Wellpoint representative working with a member identifies a potential act of discrimination. The member is advised to submit a verbal or written account of the incident and is assisted in doing so, if the member requests assistance. We document, track and trend all alleged acts of discrimination.

Members are also advised to file a civil rights complaint with TennCare's Office of Civil Rights Compliance ("OCRC"). 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.

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.

Also, information about preventing discrimination is available from the U.S. Department of Health and Human Services Office for Civil Rights (OCR):

- Through the OCR complaint portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: 800-368-1019 (TTY/TTD: 800-537-7697)

Complaint forms are available at hhs.gov/civil-rights/filing-a-complaint/index.html.

Wellpoint provides free tools and services to people with disabilities to communicate effectively with us. Wellpoint also provides free language services to people whose primary language isn't English (e.g., qualified interpreters and information written in other languages). These services can be obtained by calling the customer service number on their member ID card.

If you or your patient believe that Wellpoint has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our nondiscrimination coordinator via:

- Mail: 22 Century Blvd., Suite 310, Nashville, TN 37214
- Phone: 615-316-2400, ext. 22529
- Email: tn.nondiscrimination@wellpoint.com

Equal program access on the basis of sex
Wellpoint provides individuals with equal access to health programs and activities without discriminating on the basis of sex. Wellpoint must also treat individuals in a manner that is consistent with their gender identity and is prohibited from discriminating against any individual or entity on the basis of a relationship with, or association with, a member of a protected class (i.e., race, color, national origin, sex, gender, gender identity, age or disability).
Wellpoint may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that a different gender was assigned at birth, or because the sex or gender recorded is different from the one in which health services are ordinarily or exclusively available.

Disability Nondiscrimination Laws and their Requirements

Wellpoint policies and procedures are designed to promote compliance with Sections 504 and 508 of the Rehabilitation Act of 1973, Section 1557 of the Patient Protection and Affordable Care Act, and

Title II and Title III of the Americans with Disabilities Act of 1990 in the provision services and activities for members and participants with disabilities. Providers are required to take actions to remove existing barriers and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes:

- Street-level access.
- Elevator or accessible ramp into facilities.
- Access to lavatory that accommodates a wheelchair.
- Access to examination room that accommodates a wheelchair.
- Handicap parking clearly marked unless there is street-side parking.
- The provision of communication assistance in alternative formats, or
- The provision of other mitigating measures like a reasonable accommodation/modification or auxiliary aids and services.

Auxiliary aids or services to ensure effective communication

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the member and/or the member's representative; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, providers shall give primary consideration to the requests of members with disabilities, and/or the member's representative, in accordance with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If a member and/or the member's representative requests an auxiliary aid or service that the provider can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, the provider does not have to provide the requested auxiliary aid or service to the member and/or the member's representative. However, if available, the provider shall provide the member and/or the member's representative with another form of an auxiliary aid or service that would achieve effective communication with the member and/or the member's representative and not result in a fundamental alteration in the nature of the provider's services or result in an undue financial and administrative burden.

For more guidance see:

- ada.gov
- ada.gov/taman3.html
- hhs.gov/ocr/civilrights/resources/laws/index.html

Specifications for member materials

All written materials shall be printed with the notice of nondiscrimination and taglines as required by TennCare and set forth in TennCare's tagline template. In addition to any other requirements specified in Section A.2.17 of the CRA, Wellpoint may also provide required member materials/information electronically or on its website pursuant to the specifications set forth in

section 2.28.10, TennCare's tagline template, and the following requirements: 1) the material/information must be placed on the Wellpoint website in a location that is prominent and readily accessible for applicants and members to link to from the Wellpoint home page; 2) the material/information must be provided in a format that can be electronically saved and printed; and 3) if a member or applicant requests that Wellpoint mail them a copy of the material/information, Wellpoint must mail free of charge the material/information to them within five days of that request. To the extent that Wellpoint and its providers and/or subcontractors are using electronic and information technology to fulfill its obligations under this contract, the entities shall comply with section 2.28.10.

Non-discrimination training
In compliance with Section 2.28 of the CRA, Wellpoint providers are required to make available nondiscrimination training available to its staff.

Cost-sharing information

Copays
For adults who have Tenncare Medicaid and Medicare, Medicare pays first for health care. Then, TennCare Medicaid will pay the part of the service not paid for by Medicare, so long as the service is medically necessary and is a TennCare covered service.

There are no copays or cost sharing for TennCare enrollees with incomes below 134 percent of the Federal Poverty Level. Copays for TennCare Standard enrollees with incomes at or above 134 percent of poverty level are similar to commercial copays and the healthcare provider should collect them at the time of service. To encourage good preventive health habits, there will be no copays for preventive care visits such as:

- Well-child visits
- Immunizations
- Checkups
- Pap smears
- Prostate examinations
- Mammograms
- Family planning services
- Prenatal services

There are no deductibles or annual out-of-pocket (OOP) maximums, which apply to persons with copay obligations.

Members do not have cost sharing responsibilities for TennCare coverage and covered services, except that TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for these services. The copays are $3.00 for each branded drug and $1.50 for each covered generic drug. Generic drugs that exceed the limit of five prescriptions or refills per member per month are not covered. Family planning drugs and emergency services are exempt from copays. Members may not be denied a service for inability to pay a copayment. There is no OOP maximum on copays. Copays are administered by the PBM. Please contact the PDM directly for related questions or issues.

The following adult groups are exempt from copays:

- Members receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service
- Members who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service
- Members who are receiving services in a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities or based on a home- and community-based services waiver

Nonpharmacy copay schedule (unless otherwise directed by TennCare)

Poverty level	Copay amounts
0 percent- less than 134 percent of Federal Poverty Level (FPL)	$0.00
134 percent-199 percent of Federal Poverty Level (FPL)	$8.20 Hospital Emergency Room (waived if admitted) $5.00 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 48 hours for the same episode)
200 percent of Federal Poverty Level (FPL) and above	$50.00 Hospital Emergency Room (waived if admitted) $15.00 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 48 hours for the same episode)

** The copay amounts at the community mental health agencies exclude Tennessee Health Link and Intensive Community Based Treatment Services (e.g., CTT, CCFT, PACT).*

Member complaints

TennCare member complaint and appeals processes are compliant with all applicable federal and state laws and regulations. In addition, TennCare operates under a number of federal court orders and consent decrees, certain of which modify and/or enhance federal requirements regarding notice and hearing rights.

Members may file a complaint for causes other than adverse benefit determination taken by Wellpoint to deny, reduce, terminate, delay, or suspend a covered service as well as any other acts or omission of Wellpoint that impair the quality, timeliness or availability of such benefits. A member has the option of filing an appeal at every step of the complaint process (see Chapter 13, Adverse Actions/Appeals). For complaints related to allegations of discrimination, see the Prohibited Discriminatory Acts section of this chapter.

When a complainant member notifies Wellpoint in writing or orally of a complaint, Wellpoint fully investigates each complaint and documents the substance of the complaint, including any aspect of clinical care involved. The Wellpoint member complaint specialist oversees and coordinates the member complaint process. Wellpoint has educated its staff concerning the importance of the complaint procedure, the rights of the member and the time frames, including clinically urgent situations in which action must be taken by Wellpoint regarding the handling and disposition of a complaint.

The complainant member, within five business days of Wellpoint receipt of a complaint, is sent an acknowledgement letter, which includes any requests for additional information necessary to investigate the complaint. The total time for a Wellpoint investigation and resolution of the complaint will be within 90 calendar days from the date Wellpoint receives the initial complaint from the complainant member. A clinically urgent complaint will be handled in 72 hours. If delays are outside of the control of Wellpoint (e.g., the result of the third party's failure to provide documentation in a timely fashion or awaiting response from the complainant for additional information), Wellpoint may extend the time to respond for up to an additional 14 calendar days if within the original time frame, Wellpoint demonstrates in writing to the complainant reasonable cause for the delay beyond its control and provides a written progress report.

Wellpoint ensures that a complaint is resolved by individuals who are not directly or indirectly involved in the action or inaction, which gave rise to the complaint. After Wellpoint investigates the complaint, Wellpoint issues a resolution letter to the complainant member explaining the Wellpoint resolution. The letter will include:

- A statement of the specific contractual reasons for the resolution.
- The facts established in relation to the complaint.
- The actions, if any, that Wellpoint has taken or will take in response to the complaint.

A copy of the resolution letter will be provided to:

- Any provider identified in the complaint upon request.
- The TennCare Administration or ombudsman program representative if Wellpoint received the complaint from the state.

Complaint tracking and reporting

Upon receipt of a member complaint, Wellpoint will track the complaint through its system including tracking of all materials/records requested and received, communications with applicable parties, and all required correspondence. Complaint trending data will be reported on a quarterly and annual basis to the Quality Management Committee to identify trends and patterns for intervention. The report provides a written summary analyzing the categories of complaints, brief statements of the problem, resolution and resulting corrective actions as required.

Records will include:

- Date complaint filed.
- Date and outcome of all actions and findings.

- Date and decision of any complaint proceedings.
- Date and proceedings of any litigation.
- All letters and documentation submitted regarding the complaint.

Wellpoint maintains a complaint log categorized by cause and disposition and including length of time for resolution of each complaint. Wellpoint compiles information from the complaint log for use by the Quality Management Committee.

Complaints will be categorized by cause (according to NCQA-required reporting categories) including:

- Billing and financial or plan administration (e.g., marketing, EOBs sent to members, policy holder service or similar administrative functions, member balance billing).
- Attitude and service issues with the treating physician or provider care (e.g., lack of courteous treatment).
- Access (e.g., participating provider lacked available appointments).
- Quality of care concerns.
- Quality of provider office site (e.g., lack of wheelchair accessibility, office and/or exam rooms are dirty, office is cluttered and unorganized, etc.).

Documentation for all complaints and actions taken are maintained for a period of 10 years from the date of the receipt of the complaint. The member has a right to a copy of the complaint record within 30 calendar days of the request.

The Quality Management department will maintain complaint records and keep them readily available for state inspection.

Member appeals

Please see Adverse Action section in Section 13, Medical Management.

14. MEDICAL MANAGEMENT

Medical review criteria

Effective May 1, 2013, Wellpoint medical policies, which are publicly accessible from its subsidiary website, became the primary benefit plan policies for determining whether services are a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Wellpoint subsidiaries. The website is: provider.wellpoint.com/tennessee-provider/resources/policies-guidelines-and-manuals

Wellpoint utilizes the following criteria for behavioral and medical health services:

Behavioral health services	Criteria
All requests: outpatient, inpatient, and concurrent reviews	MCG Care Guidelines
Medical health services	**Criteria**
Outpatient	Wellpoint Medical Policies or; Clinical Utilization Management Guidelines or; Carelon Medical Benefits Management. Clinical Guidelines or; CarelonRX Clinical Guidelines and/or Policies
Inpatient site of service	MCG Care Guidelines
Inpatient concurrent reviews	MCG Care Guidelines
Inpatient Pre-Service	Wellpoint Medical Policies or; Clinical Utilization Management Guidelines or; Carelon Medical Benefits Management. Clinical Guidelines or; CarelonRX Clinical Guidelines and/or Policies or; MCG Care Guidelines
Post-Acute Services -Skilled Nursing Facility, Acute Inpatient Rehabilitation and Long-term Acute Hospital	MCG Care Guidelines
Outpatient health home care	Wellpoint Medical Policies and Clinical Utilization Management
Outpatient rehabilitation and chiropractic	Wellpoint Medical Policies and Clinical Guidelines or; Carelon Medical Benefits Management Clinical Guidelines, or; CMS guideline LCD L37254 Local Coverage Determination for Chiropractic Services

Federal and state law, as well as contract language including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or CMS requirements will supersede medical policy criteria. Medical technology is constantly evolving, and

we reserve the right to review and periodically update medical policy and utilization management criteria.

Wellpoint also works with network providers to develop clinical guidelines of care for its membership. The Medical Advisory Committee (MAC) assists Wellpoint in formalizing and monitoring guidelines.

Determinations of medical necessity are made on a case-by-case basis in accordance with the TennCare Program definition of medical necessity. Tenn. Code Ann. §71-5-144 and Tenn. Comp. R. & Regs. 1200-13-16-.05 To be determined to be medically necessary or a medical necessity, a medical item or service must be recommended by a physician who is treating the member or other licensed health care provider practicing within the scope of the physician's license who is treating the member and must satisfy each of the criteria outlined in the Medically Necessary Services — Medical Necessity section of this manual. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

Wellpoint may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide by TennCare.

All medically necessary services will be covered for members less than 21 years of age in accordance with TennCare Kids requirements.

If precertification of a service is granted by Wellpoint, payment for the precertified service will not be denied based on the lack of medical necessity, assuming that the member is eligible on the date of service, unless it is determined that the facts at the time of the denial of payment are significantly different than the circumstances, which were described at the time that precertification was granted.

If Wellpoint uses noncommercial criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development.
- Criteria are based on review of local market practice and national standards/best practices.
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated as necessary. The criteria must reflect the names and qualifications of those involved in the development, the process used in the development, and the timing and frequency at which the criteria will be evaluated and updated.

Practitioners may obtain Utilization Management (UM) criteria upon request by calling 833-731-2154.

The peer-to-peer process facilitates a conversation between a care provider and a Wellpoint Medical Director. These conversations are sometimes requested following an adverse determination notice. A discussion can be arranged by calling Utilization Management at 615-232-2121 Monday through Friday from 7 a.m. to 5 p.m. CT. The call should be used to explain or clarify something that a clinical record cannot convey. It should not be used to merely provide additional clinical information.

Please keep the following information in mind when requesting a peer-to-peer conversation. The following types of care providers may participate in a peer-to-peer process:

- Attending, treating, or ordering physician
- A covering physician for the attending, treating, or ordering physician
- The physician's nurse practitioner or physician assistant
- Departmental or specialty unit medical director
- Physician advisors (in-house or external)

All non-eligible requestors should be referred to an eligible care provider to discuss a request for a peer-to-peer conversation.

Care providers have two calendar days from the date of adverse determination notification to request a peer-to-peer conversation.

Wellpoint needs the following information to process a request for a peer-to-peer conversation:

- Member name, date of birth, and reference ID
- Care provider who is requesting the peer-to-peer conversation and a direct contact number
- The role of the care provider (for example, admitting or treating physician or facility medical director)
- Your name and telephone number

It is the policy of Wellpoint to make available a physician-to-physician (P2P) review to discuss by telephone determinations based on medical appropriateness. A physician-to-physician discussion can be arranged by calling Utilization Management at 615-232-2121 Monday through Friday from 7 a.m. to 5 p.m. CT. Provider office staff should only initiate a physician-to-physician discussion with one of our medical directors when the attending or ordering physician requests. A Physician Assistant or Nurse Practitioner is allowed to speak on behalf of the doctor that is treating the member.

Affirmative statement concerning UM decisions: UM decision-making is based only on appropriateness of care and service and existence of coverage. Wellpoint does not reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Precertification/Notification process

Wellpoint may require members to seek a referral from their PCP prior to accessing nonemergency specialty physical health services. "Precertification" is defined as the prospective process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history, and previous treatment to determine the medical necessity and appropriateness of a given request. "Prospective" means that the service request occurred prior to the provision of the service being provided. "Notification" is the telephonic, facsimile, or electronic communication received from a provider informing Wellpoint of the intent to

render covered medical services to a member prior to the rendering of such services. There is no review against medical necessity criteria for notification only services. However, member eligibility and provider status (network and non-network) are verified. The purpose of notification is to identify members who may benefit from case management such as members who require high-risk obstetrics.

If Wellpoint requires members to obtain PCP referral, Wellpoint may exempt certain services identified in the Wellpoint member handbook from PCP referral.

If a service requires precertification/notification, the provider must contact Wellpoint via phone, facsimile, or electronic communication to either obtain approval or provide the notification prior to the rendering of services. All relevant clinical information needed to determine medical necessity must be included in the request for prior authorization for a decision to be made. See Section 14 for more detailed information regarding utilization management processes for hospital and elective admission processes.

Please refer to the Precertification Lookup Tool (PLUTO) on our website for information on coverage and precertification requirements. If no precertification is required per PLUTO for In-Network providers, then Wellpoint will not review for medical necessity. Note: Out of network, in-patient admissions, and/or procedures done in an in-patient setting, require an authorization.

For members determined to need a course of treatment or regular care monitoring, Wellpoint allows members to directly access a specialist via PCP referral/extended referral as appropriate for the members' condition and identified needs.
Wellpoint will not require that a woman go in for an office visit with her PCP to obtain the referral for prenatal care.

Referral provider listing
Wellpoint provides all PCPs with a current hard copy listing of referral providers, including behavioral health providers at least 30 calendar days prior to the start date of operations. Thereafter, Wellpoint will mail PCPs an updated version of the listing on a quarterly basis. Wellpoint will also maintain an updated electronic, web-accessible version of the referral provider listing.

Exceptions to precertification and/or referrals

Other Health Insurance
If Member has Other Health Insurance (OHI) excluding Dual members that have Medicare and Medicaid with Wellpoint, no authorization should be entered for a review as the member's OHI insurance is primary and responsible for payment. Home Health Care is also excluded from the (OHI) exception.

Emergency and Post-Stabilization Care Services
Wellpoint provides emergency services without requiring precertification or PCP referral regardless of whether these services are provided by a contract or noncontract provider. Wellpoint provides post-stabilization care services.

TennCare Kids
Wellpoint does not require precertification or PCP referral for the provision of TennCare Kids screening services.

Access to women's health specialists
Wellpoint will allow female members direct access (without requiring a referral) to a women's health specialist who is a contract provider for covered services necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

Behavioral health services
Wellpoint does not require a PCP referral for members to access a behavioral health provider.

Transition of new members
Wellpoint provides for the continuation of medically necessary covered services regardless of precertification or referral requirements. However, in certain circumstances, Wellpoint may require precertification for continuation of services beyond the initial 30 days.

Clinical practice guidelines

Using nationally recognized standards of care, Wellpoint collaborates with providers to develop clinical policies and guidelines for the care of its membership. The Medical Advisory Committee (MAC) oversees and directs Wellpoint in formulating, adopting, and monitoring guidelines.

Clinical guideline forms are located online at provider.wellpoint.com/tn. Wellpoint selects at least four evidence-based clinical practice guidelines that are relevant to the member population. Wellpoint will measure performance against at least two important aspects of each of the four clinical practice guidelines annually.

Qualifying Clinical Trials
Routine patient costs that must be covered for a beneficiary participating in a qualifying clinical trial are any item or service provided to the individual under the qualifying clinical trial, including any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial . The clinical trial itself is considered investigational or experimental and is not covered by TennCare or Wellpoint Tennessee.

Advance directives

Wellpoint respects the right of the member to control decisions relating to his or her own medical care, including the decision to have any medical or surgical means or procedures calculated to prolong his or her life either provided, withheld, or withdrawn. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

Wellpoint adheres to the Tennessee Health Care Decisions Act, Tenn. Code Ann. Sections 68-11-1801 *et. seq*., and the Tennessee Right to Natural Death Act, Tenn. Code Ann. Sections 32-11-101 *et. seq*. and maintains written policies and procedures regarding advance directives. Advance directives are documents signed by competent persons giving direction to health care providers about treatment choices under certain circumstances. An advance directive, an Appointment of Health Care Agent or other instrument signed by the individual complying with the terms of Tenn. Code Ann. Sections 32-11-101 *et. seq*., or a durable power of attorney for health care complying with the terms of Tenn. Code Ann. Sections 34-6-part 2, will be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with Tenn. Code Ann. Section 68-11-1803 may be treated as an advance directive under the law. See also https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html.

Member Services and outreach associates encourage members at their first appointment with their PCP to request an *Advance Directive* form and to seek education on advance directives.

Wellpoint will provide its policies and procedures to all members 18 years of age and older and will educate members about their ability to direct their care using this mechanism. Wellpoint will designate staff members and/or providers responsible for providing this education. Neither Wellpoint nor its providers will discriminate or retaliate based on whether a member has or has not executed an advance directive.

Wellpoint, for behavioral health services, will provide its policies and procedures to all members 16 years of age and older and will educate members about their ability to direct their care using advance directives including the use of Declarations for Mental Health Treatment. Wellpoint will designate staff members and/or providers responsible for providing this education.

While each member has the right, without condition, to execute an advance directive, a facility or an individual physician may conscientiously object to an advance directive under certain limited circumstances.

Member services and outreach associates will answer questions about advance directives. No associate of Wellpoint may give legal advice or serve as witness to an advance directive or as a member's designated agent or representative.

A *Living Will* form is in Appendix A along with educational member information and forms for an Advanced Care Plan and an Appointment of a Health Care Agent.

Culturally and Linguistically Appropriate Services

Patient panels are increasingly diverse and needs are becoming more complex. It is important for providers to have the knowledge, resources, and tools to offer culturally competent and linguistically appropriate care. Wellpoint wants to help, as we all work together to achieve health equity.

The U.S. Department of Health and Human Services (HHS) defines cultural competence as the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and

families receiving services, as well as staff members who are providing such services. It is a dynamic, ongoing developmental process requiring long-term commitment. The Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network explains that healthcare is defined through a cultural lens for both patients and providers. A person's cultural affiliations can influence:

- Where and how care is accessed, how symptoms are described,
- Expectations of care and treatment options,
- Adherence to care recommendations.

Providers also bring their own cultural orientations, including the culture of medicine.

Offering culturally and linguistically appropriate care incorporates a variety of skills and knowledge, including, but not limited to, the ability to:

- Recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family members, especially minors, to act as interpreters for limited English proficient patients.
- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

Wellpoint ensures providers have access to resources to help support delivery of culturally and linguistically appropriate services. Wellpoint encourages providers to access and utilize MyDiversePatients.com.

MyDiversePatients.com: The My Diverse Patient website offers resources, information, and techniques, to help provide the individualized care every patient deserves regardless of their diverse backgrounds. The site also includes learning experiences on topics related to cultural competency and disparities that offer free Continuing Medical Education (CME) credit. Current CME offerings include:

- Caring for Children with ADHD: Promotes understanding of and adherence to diagnosis and treatment guidelines; use of AAP's Resource Toolkit for Clinicians; awareness of and strategies for addressing disparities.
- My Inclusive Practice - Improving Care for LGBTQIA+ Patients: Helps providers understand the fears and anxieties LGBTQIA+ patients often feel about seeking medical care, learn key health concerns of LGBTQIA+ patients, & develop strategies for providing effective health care to LGBTQIA+ patients.

- Improving the Patient Experience: Helps providers identify opportunities and strategies to improve patient experience during a health care encounter.
- Medication Adherence: Helps providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- Moving Toward Equity in Asthma Care: Helps providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- Reducing Health Care Stereotype Threat (HCST): Helps providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both providers' patients and practices, and how to do so.

Cultural Competency Training (Cultural Competency and Patient Engagement): A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients.

Caring for Diverse Populations Toolkit: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients.

Wellpoint appreciates the shared commitment to ensuring Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes.

Patient safety

Wellpoint strives and reinforces efforts to build a safer, equitable high-quality health care system; decrease the occurrence of patient safety events, provider preventable conditions (PPCs) and hospital-acquired and healthcare-acquired conditions (both referred to as HCACs); and ensure compliance with Federal and State regulatory requirements and BCBSA contractual requirements. We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to work with physicians, hospitals, and other healthcare partners to support patient safety efforts.

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the healthcare delivery system, including as it applies to health disparities. We advocate for safe clinical care and services; collaborate and engage with medical and behavioral health providers, as well as members, concerning patient safety; and identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum.

We select areas of focus and monitoring by analyzing patient safety for members inherent to the quality of medical and behavioral healthcare delivery and services as it applies to Population Health Management programs that targets keeping members health; managing members with both emerging risk and with chronic illnesses; enhancing health equity by addressing disparities; and patient safety or outcomes across healthcare settings.

Our goal is to support physicians and hospitals in using appropriate processes, technologies, and strategies to address never events and healthcare acquired conditions, and ultimately, to enhance the quality of care delivered to patients.

Wellpoint promotes patient safety in all aspects of care and treatment and believes that communication is a powerful tool in improving patient safety. Providers are encouraged to educate themselves and their members on actions that can be taken to improve safety. Providers can take some of the following actions to support patient safety:

- Use approved Clinical Practice Guidelines to ensure safe and appropriate care and treatment
- Identify at-risk members and use available screening tools to intervene appropriately
- Update and review members' medications including over the counter medications at each health care encounter
- Communicate legibly and clearly when writing prescriptions and when using telephonic prescribing; completely spell the medications and clearly state the prescribing instructions; adhere to The Joint Commission's official Do Not Use list of abbreviations and symbols: jointcommission.org/facts_about_do_not_use_list
- Keep legible and organized medical records and follow Wellpoint documentation and Medical Record Keeping Standards
- Review lab, radiology, and other diagnostic tests when they are received and notify members of the results in a timely manner
- Encourage members to be actively involved in their care, to ask questions and share any concerns they have about following prescribed treatments
- Communicate effectively with other providers with whom you are involved in concurrently treating members
- Keep informed about the quality performance of contracted hospitals within your network by reviewing the comparison data compiled by the Leapfrog Group's Hospital Quality and Safety Survey: leapfroggroup.org

Report quality of care concerns at State of Tennessee website for reporting safety issues – Health Care Facility Section

Notices of adverse benefit determinations/ Member Benefit Appeals (pre-service appeals)

Adverse benefit determinations

The Wellpoint medical director or designee, a licensed physician, will make all decisions for adverse benefit determinations. The reviewer must have appropriate clinical expertise in treating the member's condition or disease.

The decision regarding an authorization request for service must be made within 14 calendar days for standard request or 72 hours for expedited. TennCare may approve an extension for a standard

authorization up to 14 additional days (48 additional hours for an expedited authorization request) if the extension is in the best interest of the member.

For adverse benefit determinations, both the use of explicit medical criteria and the process of daily review by a Wellpoint medical director assure consistency in the determination of medical necessity.

Notification of adverse benefit determination
If the decision is to deny, delay, reduce, suspend, or terminate services, a notification to the member must be made in writing. The notification is based on the TennCare approved templates and includes:

- Service type and amount.
- Identity of prescriber.
- Reason(s) for the proposed action, including specific facts personal to the beneficiary.
- Plan and concise statement of cited legal or policy basis that is consistent with federal law, the TennCare waiver, rules, and contract provisions.
- Official legal citation.
- Member appeal rights.
- When the decision is deemed medically necessary, identity of the consulting clinician, medical records used to make the determination, unmet medical necessity criteria and explanation regarding the evidentiary weight given the treating physician's opinion.
- Readable explanation of discharge plan or description of specific arrangements in place to provide for continuing care (if applicable).

The attending physician and/or other ordering health care provider, the facility rendering service, and the member will be notified 10 business days prior to an adverse benefit determination by Wellpoint that reduces, suspends, or terminates ongoing services (except for inpatient hospital treatment). In instances of Wellpoint-initiated reduction, termination or suspension of psychiatric inpatient hospital treatment, the notice must be provided to a member at least two business days in advance of the proposed action.

In instances of any provider-initiated reduction, termination or suspension of the following services, the notice must be issued by said provider to a member at least two business days in advance of the proposed action:

- Any behavioral health service for a severely and/or persistently mentally ill (SPMI) adult member or seriously emotionally disturbed (SED) child
- Any inpatient psychiatric 24-hour or psychiatric residential service
- Any service being 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
- Home health services

Providers who initiate the reduction, termination, or suspension of these services are required to notify Wellpoint at least two (2) calendar days before the reduction, termination, or suspension of these services. Log in to our secure provider website and download a copy of the *PIN Request* form. Access it by selecting the Downloadable Forms link in the *Office Support* drop-down menu. Submission instructions are indicated on the PIN form. Wellpoint is required to send written notice to the Member at least two (2) business days prior to the reduction, termination, or suspension of services.

Fill in the form and submit it via one of the following options:
Fax to 877-579-6674
Email to tn1pin@wellpointcorp.com

Once we receive the completed *PIN Request* form, Wellpoint will generate the appropriate letter and PIN waiver. The Provider Initiated Notice and the Waiver are faxed to the provider to hand deliver to the member. If the member has been discharged, the Provider Initiated Notice and the Waiver are mailed to the member at the address of record. The provider should review the Provider Initiated Notice and Waiver with the member. The provider is responsible for ensuring the member receives the letter and the waiver if inpatient. If the member chooses to waive the Grier days, the provider shall submit the signed waiver to Wellpoint. Providers should not generate a generic wavier in lieu of a PIN form.

Member Benefit Appeal — (pre-service appeal)
A written notice shall be given to a Member anytime that adverse action is taken to deny, reduce, suspend, or terminate medical assistance. Members have the right to file benefit appeals regarding adverse benefit determinations taken by Wellpoint. Appeal means a member's right to contest, verbally or in writing, any adverse benefit determinations taken by Wellpoint to deny, reduce, terminate, delay, or suspend a covered service and any other acts or omissions of Wellpoint that impair the quality, timeliness, or availability of such benefits. Providers may only file a member benefit appeal with consent from the member.

Wellpoint ensures that punitive action is not taken against a provider who files an appeal on behalf of a member with the member's written consent, supports a member's appeal, or certifies that a member's appeal is an emergency appeal and requires an expedited resolution in accordance with TennCare policies and procedures.

Wellpoint will include a clear and understandable description of the method to appeal an adverse benefit determination in member handbooks, in provider manuals and through provider.wellpoint.com/tn.

Upon request, Wellpoint will provide members a TennCare approved appeal form(s).

Wellpoint will provide reasonable assistance to all appellants during the appeal process.

Members and their representative(s), including a member's provider, have 60 calendar days from receipt of the adverse benefit determination 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 will file an appeal of an adverse benefit determination with TennCare Member Medical Appeals (TMMA):

TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
Fax: 888-345-5575
Phone: 800-878-3192
TTY/TDD: 866-771-7043
Español: 800-878-3192

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

Notification of Member appeal determination
In addition to the information indicated in the notification of adverse benefit determination section of this procedure, the following will also be included in the notice of the appeal reconsideration:

- The results of the resolution process and the date the decision was completed. The member's right to request continuation of benefits during the appeal to the state's fair hearing process and that the member may be held liable for the cost of those continued benefits if the state fair hearing decision upholds the Wellpoint decision.

Member eligibility and eligibility-related grievances and appeals including termination of eligibility, effective dates of coverage, and the determination of premium and copay responsibilities will be directed to the Department of Human Services.

The medical director who reviews the clinical documentation for the appeal cannot be a subordinate of the reviewer who made the initial adverse benefit determination and must not have been involved in making the original denial.

The reconsideration of the adverse benefit determination previously made includes at least one practitioner in the same or similar specialty, including chiropractic, that typically manages the medical or dental condition, procedure, or treatment under discussion for review of the adverse benefit determination, unless otherwise indicated by the state.

The review will be conducted by an actively licensed, practicing medical doctor, doctor of osteopathy or doctor of dental surgery not involved in the initial determination.

Wellpoint is responsible for eliciting pertinent medical history information from the treating health care provider(s) for the purpose of making medical necessity coverage determinations. Wellpoint will take action (e.g., sending a provider representative to obtain the information and/or discuss the issue with the provider, imposing financial penalties against the provider for failure to request, etc.), to

address the problem if a treating health care provider is uncooperative in supplying needed information. Wellpoint will make documentation of such action available to TennCare, upon request. Providers who do not provide requested medical information for purposes of making a medical necessity determination for a particular item or service will not be entitled to payment for the provision of such item or service.

Continuation or reinstatement of services
The following services or benefits are subject to continuation or reinstatement if all applicable conditions are met:

- Those covered services currently or most recently provided to a member
- Those services being provided to a member in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the member or appropriate step-down services are not available
- Those services being provided to treat a member's chronic condition across a continuum of services when the next appropriate level of covered services is not available
- Those services prescribed by the member's provider on an open-ended basis or with no specific ending date where Wellpoint has not reissued precertification
- A different level of covered service offered by Wellpoint and accepted by the member for the same illness or medical condition for which the disputed service has previously been provided

For the services noted above, the member has the right to continue (or have reinstated) services pending final resolution of an appeal if the member appeals and requests:

- Continuation of services within 10 days of the receipt of notice of action to terminate, suspend or reduce other ongoing covered services. The member must provide written consent for the provider to request Continuation of Benefits pending the outcome of the appeal.

For all other timely requests for continuation or reinstatement requests for covered services, the services will be continued or reinstated pending appeal only if they are prescribed by the member's treating clinician.

Services will not be continued but may be immediately reduced, terminated, or suspended if the services are determined medically contraindicated.

*Continuation or reinstatement of services does not apply to CoverKids Member Appeals.

Standard appeal
The total time for a Wellpoint reconsideration of the appeal will not be more than 14 calendar days from the date Wellpoint receives appeal from the TMMA. Wellpoint provides a written notice of the outcome of the reconsideration to TMMA, and the member is notified.

If Wellpoint completes the reconsideration and overturns its previous action and approves the service, corrective action will be provided within 72 hours. If Wellpoint completes the reconsideration and upholds its earlier denial, in whole or in part, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for

precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Expedited appeal
An expedited appeal process is available for adverse benefit determinations related to time-sensitive care. Care qualifies as time-sensitive if the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee's life; physical health; mental health; or their ability to attain, regain or maintain full function.
Wellpoint must determine if the appeal is considered expedited. If the appeal is considered expedited, Wellpoint has 72 hours to respond to TennCare with the reconsideration decision. However, if the appeal is not considered expedited, it will be downgraded to a Standard appeal timeframe.* If Continuation of Benefits has been approved, the appeal will be processed as a "COB Approved" appeal.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure, or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient's representative.

The Wellpoint time frame in which the reconsideration of an expedited appeal must be completed is based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed three calendar days from the date the reconsideration request is received from TMMA. If Wellpoint upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Wellpoint has five calendar days to respond to the Division of TennCare for a "COB Approved" appeal reconsideration.

A physician or provider who has not previously reviewed the case will conduct the review. The physician or provider will be the same or a similar specialty as one that typically manages the medical condition, procedure, or treatment under review. He or she will have no direct financial interest or connection with the case. The physician or provider will review and render a final decision. The review may include an interview of the patient or patient's representative.

The Wellpoint time frame in which the reconsideration of a "COB Approved" appeal must be completed is based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed five calendar days from the date the reconsideration request is received from TMMA. However, Wellpoint may request an extension if additional time is required to obtain a member's medical/dental records.
Care is not time sensitive, and an appeal is not expedited if the member's treating physician certifies in writing that the matter is not time sensitive.

If Wellpoint upholds its original adverse benefit determination through its reconsideration process, the state then proceeds with its review of the reconsideration response, including review of the timeliness of the member's initial request for precertification of the service (if applicable) and review of the initial notice of adverse benefit determination to the member.

Request for correction of a defective notice
When a notice of adverse benefit determination that has been issued by Wellpoint is determined to be defective, the state sends an *On Request Report* to Wellpoint, identifying the notice defect(s) and requesting submission of a corrected notice that cures the deficiencies of the notice to the state within two business days for review/approval prior to issuance to the member. The state is bound by the original notice of adverse benefit determination or, if a corrected notice has been issued, by the corrected notice at hearing.

Medicaid fair hearing
If the state upholds the Wellpoint reconsideration determination, the member's appeal is automatically forwarded to TennCare and docketed for fair hearing before an Administrative Law Judge (ALJ).

Neither Wellpoint nor TennCare will prohibit or discourage any individual from testifying on behalf of a member.

If the ALJ rules in favor of the member, a directive is issued to Wellpoint for the requested service. Implementation of the corrective action and proof of such action must be submitted to the Directive Services Unit within 72 hours except upon demonstration of good cause.
TennCare may develop additional appeal process guidelines or rules, including requirements as to content and timing of notices to members, which will be followed by Wellpoint. However, Wellpoint will not be precluded from challenging any judicial requirements; and to the extent judicial requirements that are the basis of such additional guidelines or rules are stayed, reversed or otherwise rendered inapplicable, Wellpoint will not be required to comply with such guidelines or rules during any period of inapplicability.

Demonstration of good cause
Good cause is limited to circumstances that are beyond the control of Wellpoint and that have been shown, based on documented diligent efforts to implement the decision, to prevent its timely implementation. Good cause may also be requested if Wellpoint believes the directive requires the provision of a medical item or service that is medically contraindicated for the member. Such request must then include documentation that supports the Wellpoint finding of medical contra-indication for review by the TennCare Office of the Medical Director (OMD).

A good cause request for extension of the 72-hour timeline for implementation of corrective action must be submitted in writing to the DSU and must be received by the DSU on or before the compliance date along with documentation of diligent efforts to provide corrective action within five calendar days or documentation that supports a finding of medical contraindication. If the good cause request is approved by the OCCP (or, in the case of contraindication, by the OMD), written notification including a revised compliance date, if applicable, will be provided.

Single state agency review and final agency action
Pursuant to Section 1902(a)(3) of the Social Security Act and federal regulations at 42 C.F.R. 431, subpart E., the single state agency must retain the authority to review or overturn the decisions of nonagency hearing officers when contrary to applicable law, regulations or agency policy interpretations.

An ALJ order is not, therefore, deemed final pending review and final agency action by the single state agency in order to determine whether such ruling is contrary to applicable law, regulations or agency policy interpretations, including decisions regarding the defined package of covered benefits, determinations of medical necessity, and decisions based on incorrect interpretation/application of the TennCare Rules. Review by the single state agency does not relieve Wellpoint of its responsibility to implement prompt corrective action within five calendar days of a decision in favor of the member. However, to the extent that the ruling is subsequently determined by the state to be contrary to applicable law, regulations or agency policy interpretations, the state will not be prohibited from taking timely final agency action and immediately implementing such order to reduce, suspend or terminate such service for which corrective action had been provided since the fifth day from issuance of the order by the ALJ.

TennCare Member Medical Appeals
P.O. Box 000593
Nashville, TN 37202-0593
Fax (toll free): 888-345-5575

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.

Appeal Reason	Appeal Requestor	Appeal Submission Address/Fax
Denial of a new service that has not been rendered	Member/Provider	TennCare PO Box 593 Nashville, TN 37202-0593 Fax Number: 888-345-5575 Phone: 800-878-3192
Delays, reduction, suspension, or termination of existing services for Members	Member/Provider	TennCare PO Box 593 Nashville, TN 37202-0593 Fax Number: 888-345-5575 Phone: 800-878-3192
Denial of a claim for any reason (i.e, no prior auth obtained, timely filing)	Provider	Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599 Phone: 833-731-2154

		Online: Availity.com
Medical Necessity Denial of a service that has already been rendered	Provider	Provider Payment Disputes P.O. Box 61599 Virginia Beach, VA 23466-1599 Phone: 833-731-2154 Online: Availity.com

Member Appeals tracking and reporting

Upon receipt of an *On Request Report* (*ORR*) from the TennCare Member Medical Appeals, Wellpoint will track the appeal through its core processing and document management systems including tracking of all materials and records requested and received, communications with applicable parties, and all required correspondence. Appeals and data will be trended through our Quality Management department. Appeals trending data will be reported on an annual basis to the Quality Management Committee (QMC) meeting.

Records will include:

- Date filed.
- Date and outcome of all actions and findings.
- Date and decision of any appeal proceeding.
- Date and proceedings of any litigation.
- All letters and documentation submitted regarding the appeal.

The Wellpoint appeal system modules will categorize by cause and disposition and include length of time for resolution of each appeal.

Documentation for all appeals and actions taken are maintained for a period of six years from the date of the receipt of the *ORR*. The member has a right to a copy of the record within 30 calendar days of the request.

Wellpoint requires providers to display notices of members' rights to appeal adverse benefit determinations affecting services in public areas of each facility in accordance with TennCare rules and regulations. Wellpoint will ensure that providers have correct and adequate supply of public notices.

Permitted sanctions

Wellpoint may impose sanctions for a provider's failure to comply with contractual and/or credentialing requirements, or failure or refusal to respond to the request for information by Wellpoint including credentialing documentation, medical records and other records demonstrating the medical care provided to members. At the discretion of Wellpoint or by specific directive of

TennCare, Wellpoint may impose sanctions against the provider as appropriate generally in accordance with the following chart:

Examples of permitted sanctions

Program issues	Damage
Failure to comply with the TennCare Contractor Risk Agreement and federal rules/law regarding sterilizations/abortions/hysterectomies	$500 per occurrence or the actual amount of any federal penalty for the failure of Wellpoint to comply, whichever is greater
Failure to provide coverage for prenatal care without a delay in care	$500 per day per occurrence for each calendar day that care is not provided in accordance with the terms of this Agreement
Failure to provide a timely and complete response to a TennCare request for Wellpoint's internal Appeal file or for Appeal related documentation, such as notices issued to enrollee, medical records, and prior authorization requests and decisions.	$500 per calendar day Wellpoint is in default
Failure to provide a written discharge plan or provision of a defective discharge plan from a psychiatric inpatient facility or mental health residential treatment facility	$1,000 per occurrence per case
Failure to timely provide an approved service as required in this Agreement or required by or within reasonable promptness; or failure to issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of the services not provided plus $500 per day per occurrence for each day: 1. Approved care is not provided timely 2. Notice of delay is not provided and/or Wellpoint fails to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
Failure to comply in any way with encounter data submission requirements (excluding the failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare)	Up to $25,000 per occurrence depending on the circumstances

Program issues	Damage
Failure to (1) provide an approved service timely, i.e., in accordance with timelines specified in this Contract, or when not specified therein, with reasonable promptness; or (2) issue appropriate notice of delay with documentation upon request of ongoing diligent efforts to provide such approved service	The cost of services not provided plus $500 per day, per occurrence, for each day: 1. that approved care is not provided timely; or 2. notice of delay is not provided and/or Wellpoint to provide upon request sufficient documentation of ongoing diligent efforts to provide such approved service
Failure to review nursing and aide care notes and the results of face-to-face assessments, including care coordination or case management visits conducted by Wellpoint prior to the reduction of any covered home health or private duty nursing services prescribed by a treating physician for a chronic condition, or to provide such documentation which supports Wellpoint medical necessity determination to TENNCARE upon request.	The cost of home health or private duty nursing services not provided plus $500 per day, per occurrence, for each day that care was not provided (i.e., denied or reduced)
Failure to address or resolve problems with individual encounter records in a timely manner as required by TennCare	An amount equal to the paid amount of the individual encounter record(s) that was rejected or, in the case of capitated encounters, the fee-for-service equivalent thereof as determined by TennCare

Wellpoint retains the right to impose sanctions on a provider in an amount up to the amount assessed by any regulatory agency for any Wellpoint deficiency that is directly caused by that provider's actions or omissions. Wellpoint will retain a record of the sanctions imposed as required by TennCare.

15. SERVICE AUTHORIZATIONS

Hospital and elective admission management

Wellpoint requires precertification of all inpatient elective and/or planned admissions. The referring or specialty physician identifying the need to schedule a hospital admission must submit the request for precertification. Requests for precertification should include all supporting documentation and be submitted as far in advance as possible but no later than 72 hours prior to the scheduled admission. This can be done via the secure provider website Availity.com or faxing the information into the health plan. This will allow Wellpoint to verify benefits and process the precertification request.

For services that require precertification, Wellpoint makes case-by-case determinations that consider the individual's health care needs and medical history in conjunction with Tennessee's medical necessity criteria along with MCG Care Guidelines. Depending on the requested procedure(s) and/or CPT code(s) Carelon Medical Benefits Management and Wellpoint Guidelines may be utilized. Provider should utilize Precertification Look-Up Tool (PLUTO) available via provider portal to determine appropriate process for submission of request (Availity).

Notification or Request Prior Authorization
The quickest, most efficient way to request prior authorization is through Availity Essentials at Availity.com. Through this secure multi-payer platform, you can access the digital authorization application, which offers a streamlined and efficient experience for providers requesting inpatient and outpatient behavioral health services for Wellpoint members. Providers can also use this application to inquire about previously submitted requests regardless of how they were submitted (phone, fax, or other online tool).

- Initiate preauthorization requests online, eliminating the need to fax. The digital authorization application allows detailed text, photo images and attachments to be submitted along with your request.
- Review requests previously submitted via phone, fax, or other online tool.
- Instant accessibility from almost anywhere, including after business hours.
- Utilize the dashboard to provide a complete view of all utilization management requests with real-time status updates.
- Real-time results for some common procedures.
- Access the digital authorization application from the Patient Registration menu on Availity Essentials home page. Select *Authorizations and Referrals*.
- Enhanced Analytics that can provide immediate authorizations for certain higher levels of care
- Increased Efficiency so that use of fax is no longer needed

For an optimal experience with the digital authorization application, use a browser that supports 128-bit encryption. This includes Microsoft Edge, Chrome, or Firefox.

You may also request authorizations for inpatient mental health services via the Availity Essentials secure multi-payer platform, 24 hours a day, 7 days a week, 365 days a year. Please be prepared to

provide clinical information in support of the request. See Behavioral Health Services (section 9) for additional information. Fax forms are on our website at provider.wellpoint.com/tennessee-provider/home. Our website will be updated as additional functionality, and lines of business are added throughout the year.

Wellpoint is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and aligns with appropriate guidelines, a Wellpoint reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

Wellpoint will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition.

Wellpoint may deny services that are not covered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare and/or an Administrative Law Judge.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If medical necessity criteria for the admission are not met on the initial review, the medical director may attempt to contact the requesting physician to discuss the case. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service and the medical director will evaluate the new information considering the member's individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

If the precertification documentation is incomplete or inadequate, the precertification nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Again, the provider will be asked to provide further information as described above.
If the medical director denies coverage of the request, the appropriate notice of action (including the member's appeal rights) will be faxed to the requesting provider and mailed to the member within mandated time frames.

Newborn authorization requirements

Only non-routine newborn inpatient services require an authorization. When billing non-routine newborn level of care, an approved authorization is required and must be on file for us to consider the claim for non-routine newborn reimbursement.

For newborn inpatient claims billing services other than a normal newborn admission for which there is no authorization on file, reimbursement will equal the normal newborn rate (DRG 795) if the mother's delivery admission is authorized and on file.

Newborn claims for which neither the mother nor the newborn have an authorization on file will be denied for no authorization. Normal newborns do not require authorization. These claims will be processed under the mother's approved authorization.

This will appear on your *Explanation of Payment* for newborn claims billing a higher level of care without the required authorization on file. You must notify us of any newborn admissions that are not normal newborns within one business day of the admission. It is not necessary to notify us of normal-newborn admissions.

For non-routine newborn admissions, please fax your request with the supporting clinical information to 877-423-9975.

Providers Participating in the ADT (admission, discharge, and transfer) Process

Effective January 1, 2024, requests for urgent (emergent) hospital admissions are no longer required within 24 hours or by the next business day after the inpatient admission order. Inpatient acute care hospitals can now send admission, discharge, and transfer (ADT) data directly to Wellpoint in Tennessee. Through agreements with TennCare and the Tennessee Hospital Association, the health plan receives data feeds. This means Wellpoint is notified in real time when a member is admitted to an inpatient facility for an urgent admission. Inpatient participating network hospital providers will not be issued a denial for noncompliance. Clinical information for the urgent admission supporting medical necessity should still be submitted.

Please note other prior authorization guidance remains unchanged:

- Inpatient prior authorization admissions continue to require authorization for claims payment. Facilities must submit clinical information to ensure inpatient care is medically necessary.
- Post-acute authorizations (skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care facilities) and elective (scheduled) inpatient admissions will still require prior authorization before the member is admitted or transferred.
- Inpatient behavioral health facilities are still required to submit authorization requests within 24 hours or one business day of admission.
- Sending clinical information in a timely manner will help us assist you with discharge planning needs.

You can submit clinical information several ways:

- Online: Availity.com
- Phone: 833-731-2154
- Fax: 877-423-9975

Discharge notification requirements
Hospitals must notify Wellpoint of the member's discharge from the acute hospital stay within 24 hours after a weekday discharge. For weekend and holiday discharges, notification should be received by close of business on the next business day.

Emergent admission notification requirements

Wellpoint prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Wellpoint of emergent admissions within one business day. The Utilization Management nurse will review the requested admission along with the supporting medical documentation utilizing MCG Care Guidelines to determine the medical appropriateness.

If the documentation is incomplete or inadequate, the Utilization Management nurse will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation. Again, the provider will be asked to provide further information as described above. If the supporting clinical information is not provided within 24 hours of request, the request will be sent to the medical director for review and possible denial.

If the medical director denies coverage of the request, the appropriate notice of action (including the provider's appeal rights) will be faxed to the provider.
We are available 24 hours a day, 7 days a week to accept emergent admission notification at 833-731-2154.

Nonemergent outpatient and ancillary services — precertification and notification requirements

Wellpoint requires precertification for coverage of selected nonemergent outpatient and ancillary services (see chart below). To ensure timeliness of the authorization, the expectation of the facility and/or provider is that the following must be provided at the time of the request for prior authorization:

- Member name and ID
- Name, telephone number and fax number of physician performing the selective service
- Name of the facility and telephone number where the service is to be performed
- Date of service, frequency of service and length of time if known
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code

- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

Requests for prior authorization with all supporting documentation should be submitted at least 72 hours prior to rendering services. For services requiring precertification, Wellpoint makes case-by-case determinations that consider the individual's health care needs and medical history in conjunction with the TennCare required medical necessity rules and regulations and appropriate Wellpoint review criteria.

Wellpoint is available 24 hours a day, 7 days a week to accept precertification requests via phone, fax, or digitally, through Availity Essentials. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

Wellpoint may administratively deny any request for service rendered prior to receipt of the request.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the provider in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the Tennessee definition of medical necessity and in conjunction with the approved Wellpoint review criteria, a Wellpoint reference number will be issued within 14 days (or as expeditiously as the member's health condition warrants) to the provider. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

Wellpoint will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness or condition.

Wellpoint may deny services that are noncovered except as otherwise required by TennCare Kids or unless otherwise directed to provide them by TennCare.

All medically necessary services will be covered for members under 21 years of age in accordance with TennCare Kids requirements.

If the request is urgent in nature (expedited service authorization), the decision will be made within 72 hours upon receipt of all necessary documentation. As defined by 2020 NCQA Standards for Utilization Management – an Urgent Request is: A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations.

If the precertification documentation is incomplete or inadequate, the nurse will not approve coverage of the request but will instead notify the provider to submit the additional necessary documentation.

If medical necessity criteria for the service are not met on the initial review, the requesting provider may contact the health plan and request to discuss the case with the medical director conducting the review. The provider will be asked in this instance to provide further explanation and/or evidence in support of the requested service, and the medical director will evaluate the new information considering the member's individual circumstances. If the provider fails to provide additional justification or the additional justification fails to cure the original deficiency, the medical director may issue a denial of coverage.

If the medical director denies the request for coverage, the appropriate notice of action will be faxed or mailed to the requesting provider, the ordering physician (if different than the requesting), and mailed to the member within mandated time frames.

Hospice

Hospice authorizations (Q codes) are not required for all members (members enrolled in both Medicare and Medicaid) as of July 1, 2017.

Although authorization is not a requirement at this time, Wellpoint medical directors may reach out to discuss members who are receiving benefits beyond 3-6 months.

Authorization is required for Service Intensity Add-On (SIA) procedure codes G0299, G0300 and G0155. SIAs are post-authorization requests and can be requested up to two weeks after a member's death. When completing the *Precertification Request* form, please include all member and provider information, as well as the member's date of death, dates of service for SIA, number of visits/hours and procedure code(s). Fax the request to 866-495-5789.

Outpatient concurrent review

If the provider deems additional services are indicated beyond the approved services, the provider must recontact Wellpoint prior to the expiration of the original authorization to obtain an extension. The provider should use the same process used to obtain the prior authorization for the services.

Outpatient and Inpatient Precertification/Notification Requirements

Precertification/notification coverage requirements		
Service	Requirement	Comments
Cardiac rehabilitation	Precertification	Precertification is required for coverage of all services.

Precertification/notification coverage requirements		
Service	Requirement	Comments
Chemotherapy		• Procedures related to the administration of approved chemotherapy medications do not require approval when performed in outpatient settings by a participating facility, provider office, outpatient hospital or ambulatory surgery center. • For information on coverage of and precertification requirements for chemotherapy drugs, please refer to the Precertification Lookup Tool on our website. • Precertification is required for coverage of inpatient chemotherapy.
Chiropractic		Medicaid eligible, age 21 and older: No precertification is required. Chiropractic care will only be covered for spinal manipulation and must include spine ICD-10-CM codes. Maintenance therapy will not be covered. The chiropractor will be allowed to perform spine X-rays per area to include cervical, thoracic, lumbar, sacroiliac joint, and sacral region once per calendar year. DME is not covered when ordered by a chiropractor as part of the treatment plan of care. Medicaid/Standard eligible, under age 21: No precertification is required. Covered as medically necessary in accordance with TennCare Kids requirements. CoverKids: No precertification is required. Covered by the CoverKids program for children under age 19 as medically necessary. Maintenance visits not covered when no additional progress is apparent or expected to occur. Mothers (Age 19 and over) of Eligible Unborn Children: Not Covered.
Court-ordered services		Court-ordered behavioral health services will be provided in accordance with state laws. Wellpoint may apply medical necessity criteria after 24 hours of emergency services unless there is a court order prohibiting release. Mandatory Outpatient Treatment: Wellpoint will provide mandatory outpatient treatment for members found not guilty by reason of insanity following a 30- to 60-day inpatient evaluation or for other reasons. Treatment can be terminated only by the court.
Dermatology services		No precertification is required for network provider for evaluation and management (E&M) services. Services

Precertification/notification coverage requirements		
Service	Requirement	Comments
		considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. Please refer to the Precertification Lookup Tool on our website for information on precertification requirements.
Diagnostic testing		• No precertification is required for tests performed in conjunction with a precertified inpatient stay. • Please refer to the Precertification Lookup Tool on our website for information on precertification requirements • Precertification is through Carelon Medical Benefits Management for CTA, MRA, MRI, CT scans, nuclear cardiology, stress echocardiography (SE), Echo, resting transthoracic echocardiography (TTE) and PET scans. • To initiate a review request with Carelon Medical Benefits Management, please visit www.providerportal.com or call Carelon Medical Benefits Management at 844-767-8159 Monday-Friday from 8 a.m.-8 p.m. ET. Fax requests will no longer be accepted. Carelon Medical Benefits Management will help locate a preferred imaging facility from the Wellpoint network of radiology service providers.
Durable medical equipment (DME)		All DME, including all referrals, should be coordinated through Wellpoint Utilization Management (UM). Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements. Note: Effective July 1st, 2024, Wellpoint Tennessee Medicaid in accordance with Public Chapter No. 1050 and Senate Bill No. 2368 will cover and reimburse medically necessary repairs on Complex Rehab Technology (CRT) annually for at least one preventive maintenance visit. CRT providers are required to complete the Tennessee Department of Commerce and Insurance Attestation Form available at: TDCI Compliance Attestation Form. All paid claims are subject to audit and recoupment if no attestation form is on file.

Precertification/notification coverage requirements		
Service	Requirement	Comments
		Any additional parts or equipment that are part of the repair must be billed with the modifier MS to waive precertification requirements. Providers are recommended to use the precertification lookup tool at Precertification lookup tool | Wellpoint Tennessee, Inc. for precertification requirements.
Educational consultation	No precertification	No notification or precertification is required for diabetic/nutritional or weight management counseling.
Emergency room	Self-referral	No notification is required for emergency care given in the ER. If emergency care results in admission, notification to Wellpoint is required within 24 hours or the next business day. For observation precertification requirements, see Observation.
ENT services (otolaryngology)		No precertification required for in-network provider for evaluation and management services. Precertification required for tonsillectomy and/or adenoidectomy; nasal/sinus surgery and cochlear implant surgery and services. Please refer to the Precertification Lookup Tool on our website for information on precertification requirements
Family planning/STD care	Self-referral	Members may self-refer to an in-network provider. Covered services include pelvic and breast examinations, lab work, drugs, biological, genetic counseling, devices, and supplies related to family planning (e.g., an intra-uterine device). Infertility services and treatments are not covered.
Gastroenterology services		No precertification required for network provider for Evaluation and Management. Precertification is required for upper endoscopy, bariatric surgery, including insertion, removal and/or replacement of adjustable gastric restrictive devices and subcutaneous port components. Please refer to the Precertification Lookup Tool on our website for information on precertification requirements.
Genetic testing		If precertification is required, most services will be provided through Carelon Medical Benefits Management (CMBM).

Precertification/notification coverage requirements		
Service	Requirement	Comments
		Please utilize PLUTO (Precertification Look Up Tool) provider.wellpoint.com/ttn/resources/precertification/precertification-lookup to view if service is authorized by CMBM. The ordering provider is responsible for obtaining an authorization., You can access Carelon Medical Benefits Management at providerportal.com. You can also contact Carelon Medical Benefits Management toll free at 844-767-8159 or follow the instructions per PLUTO. Note: Rapid Whole Genome Sequencing (rWGS) benefit is covered under *Public Chapter No. 1020* of the *Tennessee Code Annotated, Titles 8, 56, and 71*, specifically section *71-5-107*. rWGS involves examining the entire human genome to detect genetic changes that might cause diseases. Preliminary results are usually available within seven days, with final results ready within 15 days of receiving the sample. Please use the following billing codes for rWGS and note that we do not require preapproval for these codes: • 0425U — Genome (for example, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (for example, parents, siblings) • 0094U — Genome (for example, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis rWGs is covered as a separately payable service for our members when specific clinical criteria are met. This criterion includes the following conditions: 1. The beneficiary is under 21. 2. The beneficiary has a complex or acute illness of unknown etiology, that is not confirmed to be caused by environmental exposure, toxic ingestion, an infection with normal response to therapy, or trauma; and 3. The beneficiary receives hospital services in an intensive care unit or other high-acuity care unit. Please note that the parent of the member will also be eligible if also covered by TennCare (Wellpoint) benefits.

Precertification/notification coverage requirements		
Service	Requirement	Comments
Hearing aids		Precertification is required for hearing aids for members under 21 years of age. Hearing services, including the prescribing, fitting, changing of hearing aids, and cochlear implants for members older than 21 years of age are not a covered benefit.
Hearing screening	No precertification	No notification or precertification is required for coverage of diagnostic and screening tests, hearing aid evaluations and counseling. Audiological therapy or training not covered for members 21 years of age or older.
Home Health care	Precertification	• No precertification required for members under 21 years of age for Home Health Physical, Occupational, and Speech Therapy, Home Health Skilled Nursing visits. • No precertification on the first 12 visits per plan year for members over the age 21 if performed by In-Network providers for the following services: Home Health Skilled Nursing(G0299/G0300), Physical Therapy/Physical Therapy Assistant(G0151/G0157), Occupational Therapy/Occupational Therapy Assistant(G0152/G0157), Speech Therapy (G0153) • Rehabilitation Therapy, drugs and DME require separate precertification if required. • The use of Electronic Visit Verification (EVV) is required for payment for all home health and private duty services per CMS guidelines. Wellpoint uses Carebridge Health as our EVV system and claims submission. For additional information, reach out to TNEVV@Wellpoint.com
Hospice		• Hospice Q codes do not require authorization. • SIA Add-On Codes (G0299, G0300 and G0155.) require authorization.
Hospital admission	Precertification	• Elective and planned admissions require precertification for coverage. Minimum of 72-hour notification. • Emergency admissions require notification within 24 hours or the next business day.

Precertification/notification coverage requirements		
Service	Requirement	Comments
		• To be covered, preadmission testing must be performed by a Wellpoint preferred lab vendor. See provider referral directory for a complete listing of participating vendors. • Respite Care; personal comfort and convenience items; and supplies not directly related to patient care are not covered. Examples are cell phone charger, movie rentals, and take-home supplies. • For non-routine newborn inpatient admissions, please refer to non-routine newborn admissions below.
Laboratory services (outpatient)		• Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements provider.wellpoint.com/tn/resources/precertification/precertification-lookup • Precertification is required for all laboratory services furnished by non-network providers, except for hospital laboratory services in the event of an emergency medical condition. • Hospitals may only perform STAT labs. • To ensure outpatient laboratory services are directed to the most appropriate setting, providers may perform laboratory testing in their offices but must otherwise direct outpatient diagnostic laboratory tests to a Wellpoint participating lab such as Quest Diagnostics or LabCorp. You can find a list of participating laboratories in our provider referral directory available on our website.
Lactation Services		• Eligible patients may receive medically appropriate outpatient services during pregnancy and through the extended postpartum period. • Patients can receive services in a one-on-one or small group setting. • In-person or through telehealth (using the appropriate Place of Service code). • Eligible patients include birth parents or babies with TennCare or CoverKids coverage.

Precertification/notification coverage requirements		
Service	Requirement	Comments
		• When billing for lactation services, use the appropriate codes below plus the modifier U8: 98960 U8 single individual per 30 minutes 98961 U8 2-4 patients per 30 minutes 98962 U8 5-8 patients per 30 minutes 1 unit: visit 16-45 minutes 2 units: visit 46-75 minutes 3 units: visit 76-105 minutes • There's no limit on the number of visits allowed, but additional information may be requested if a provider submits >15 units per patient. • For additional information please visit https://providernews.wellpoint.com/tn/articles/state-communication-lactation-consultation-benefit-update-16-16427
Medical supplies		All medical supplies, including all referrals, should be coordinated through Wellpoint Utilization Management (UM). Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements provider.wellpoint.com/tn/resources/precertification/precertification-lookup
Neurology		No precertification required for network provider for E&M and most procedures. Precertification is required for neurosurgery, spinal fusion, and artificial intervertebral disc surgery. See diagnostic testing.
Newborn nursery inpatient admissions	No Precertification	Normal newborn inpatient admissions do not require authorization if approved delivery authorization for the mother is on file. For non-routine newborn inpatient admissions, refer to the non-routine newborn admissions below.
Non-routine newborn admissions	Precertification	Precertification is required for non-routine newborn inpatient admissions. Fax your precertification requests to 877-423-9975.

Precertification/notification coverage requirements		
Service	Requirement	Comments
Observation	No precertification	• No precertification or notification required for in-network observation. If observation results in inpatient admission, notification to Wellpoint is required within 24 hours or the next business day from date of observation conversion to inpatient admission
Obstetrical care		• No precertification is required for coverage of obstetrical services, including obstetrical visits, diagnostic tests and laboratory services when performed by a participating provider. • Notification to Wellpoint is required at the first prenatal visit. No precertification is required for coverage of labor, delivery, and circumcision for newborns up to 12 weeks of age. • No precertification is required for the ordering physician for OB diagnostic testing. • Notification of delivery is required within 24 hours with a completed newborn assessment. Required Newborn information includes: Date of Birth (DOB), Birth weight, Gender, Gestational age, Live birth, APGAR, and Type of delivery • OB case management programs are available. • See diagnostic testing.
Ophthalmology		• No precertification required for Evaluation and Management Services with an in-network provider. • Precertification is required for repair of eyelid defects. Services considered cosmetic in nature are not covered. See diagnostic testing. • Ophthalmology procedures please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements.
Oral maxillofacial	Precertification	See plastic/cosmetic/reconstructive surgery.
Otolaryngology (ENT) services	See ENT services (otolaryngology)	
Out-of-area/out-of-plan care	Precertification	Precertification is required except for coverage of emergency care (including self-referral).

Precertification/notification coverage requirements		
Service	Requirement	Comments
Outpatient/ ambulatory surgery		Precertification requirement is based on the service performed. For information on coverage and precertification requirements, please refer to the Precertification Lookup Tool on our website.
Pharmacy		Outpatient pharmacy benefits are covered by TennCare. Products considered non-self-administered and obtained in an office or clinic setting are to be billed to Wellpoint. Injectable drugs obtained directly from a pharmacy provider are to be billed directly to the TennCare program. The injectable drugs covered under the pharmacy benefit, located at optumrx.com/oe_tenncare/prescriber are available by having the member obtain the drug through his or her local pharmacy. The pharmacy must bill TennCare. Some of these drugs require precertification through TennCare to ensure clinical criteria are met. For full details, please refer to the TennCare program. Wellpoint reimburses providers for certain injectables administered in a provider's office as well as home infusion. Please refer to the Precertification Lookup Tool on our website at provider.wellpoint.com/tn under Resources.
Physical medicine and rehabilitation (including pain management)	Precertification	Precertification is required for coverage of majority of services and procedures related to pain management. Please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements provider.wellpoint.com/tn/resources/precertification/precertification-lookup

Precertification/notification coverage requirements		
Service	Requirement	Comments
Plastic/cosmetic / reconstructive surgery (including oral maxillofacial services)		• No precertification is required for coverage of E&M codes. • All other services require precertification for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered (e.g., scar revision or keloid removal resulting from pierced ears). Reduction mammoplasty requires a post service medical necessity review upon claim submission. • No precertification is required for coverage of oral maxillofacial E&M services. • Precertification is required for the coverage of trauma to the teeth and oral maxillofacial medical and surgical conditions, including temporomandibular joint disorder.
Podiatry		No precertification for coverage of E&M, testing and most procedures when provided by a participating podiatrist.
Prosthetics and Orthotics		Precertification is required for coverage of certain prosthetics and orthotics. For code-specific precertification requirements for prosthetics and orthotics ordered by a network provider or facility, refer to our online *Precertification Lookup Tool* at provider.wellpoint.com/tennessee-provider/resources/precertification/precertification-lookup
Radiation therapy	Precertification	All radiation therapies and procedures are reviewed by Carelon Medical Benefits Management. To initiate a review request with Carelon Medical Benefits Management, please visit providerportal.com or call Carelon Medical Benefits Management at 844-767-8159 Monday through Friday from 8 a.m. to 8 p.m. ET.
Radiology services	See diagnostic testing	

Precertification/notification coverage requirements		
Service	Requirement	Comments
Rehabilitation therapy (short term): OT, PT, RT and ST	Precertification	• Providers should verify precertification rules by using the Precertification Lookup Tool on our website for information on coverage and precertification requirements. provider.wellpoint.com/tn/resources/precertification/precertification-lookup • Therapy services that are required to improve a child's ability to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary.
Skilled nursing facility	Precertification	Precertification is required for coverage. Requests should be faxed to 866-920-6005.
Sleep study	Precertification	Precertification is required. All sleep management requests are reviewed by Carelon Medical Benefits Management. To initiate a review request with Carelon Medical Benefits Management, please visit providerportal.com or call 844-767-8159 Monday-Friday from 8 a.m. to 8 p.m. ET.
Sterilization	No precertification	• Sterilization services are a covered benefit for members age 21 and older. • No precertification or notification is required for coverage of sterilization procedures including tubal ligation and vasectomy, performed as an out-patient procedure. • A *Sterilization Consent* form is required for claims submission for the procedure, not the consultation. Forms are located at https://www.tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html • Reversal of sterilization is not a covered benefit. • Sterilization for Gender Affirming Care is not a covered benefit.
TennCare Kids/EPSDT office visits	Self-referral	Use TennCare Kids schedule and document visits.

Precertification/notification coverage requirements		
Service	Requirement	Comments
Transportation		• All nonemergency medical transportation, including facility discharges should be coordinated through Tennessee Carriers. • Out of state travel requires precertification through health plan based on case-by-case review.
Urgent care center		No notification or precertification is required for a participating facility.
Urology		For Urology procedures please refer to the Precertification Lookup Tool on our website for information on coverage and precertification requirements. No precertification required for Evaluation and Management Services with an in-network provider.

Precertification/notification coverage requirements		
Service	Requirement	Comments
Weight management services		Members who need or are interested in weight management services can be referred to Member Services at 833-731-2153 (TTY 711). For in-network providers, no notification or precertification is required for diabetic/nutritional or weight management counseling. Mid Cumberland Region — Lifestyle Balance Program via County Health Departments Dickson: 615-797-5056 Humphreys: 931-296-2231 Williamson: 615-794-1542 Rutherford: 615-898-1891 Stewart: 931-232-5329 Montgomery: 931-648-5747 Davidson: • Matthew Walker Comprehensive Health Center: 615-327-9400 • United Neighborhood Health Services: 615-226-1695 Member should contact local health department or FQHC for an appointment. Local Health Department — Registered Dietician or Nutritionist available by appointment only. Bedford: 931-684-3426 Maury: 931-388-5757 Upper Cumberland Region — Local Health Departments (Nutritionist available by appointment only) All counties in the region.
Well-woman exam	Self-referral	Well-woman exams are covered one per calendar year when performed by a PCP or in-network GYN. Exam includes routine lab work, STD screening, Pap smear and mammogram (age 35 or older), every two years or more frequently on physician recommendation for ages 40-50 and annually for ages 50 and older.
Revenue (RV) codes		To the extent the following services are covered benefits, precertification (preauthorization) or notification is required for all services billed with the following revenue codes: • All inpatient and behavioral health accommodations

Precertification/notification coverage requirements		
Service	Requirement	Comments
		• 0023 — Home health prospective payment system • 0240 through 0249 — All-inclusive ancillary psychiatric • 0250 — Pharmacy general • 0632 — Pharmacy multiple source • 3101 through 3109 — Adult day care and foster care

Precertification/notification coverage requirements for behavioral health

Precertification/notification coverage requirements for behavioral health		
Service	Precertification required for in-network provider?	Precertification required for out-of-network provider?
Psychiatric Inpatient Hospital Services	Yes	Yes
23-hour Observation Bed	No	Yes
24 Hour Psychiatric Residential Treatment	Yes	Yes
Outpatient Mental Health Services:		
MD Services (Psychiatry)	No	Yes
Outpatient Non-MD Services	No	Yes
Partial Hospitalization	Yes	Yes
Intensive Outpatient	Yes	Yes
Inpatient, Residential and Outpatient Substance Use Disorder Services:		
Inpatient Facility Services (including detoxification)	Yes	Yes
Residential Treatment Services	Yes	Yes
Partial Hospital	Yes	Yes
Intensive Outpatient	Yes	Yes
Outpatient Treatment Services	No	Yes
Ambulatory Detoxification	Yes	Yes
Intensive Community Based Treatment (includes Continuous Treatment Team (CTT), Comprehensive Child and Family Treatment (CCFT), Program of Assertive Community Treatment (PACT)	Yes	Yes
Psychiatric Rehabilitation Services (includes psychosocial rehabilitation, supported employment, peer recovery, family support services, illness management and recovery)	No	Yes
Psychiatric Rehabilitation Services	Yes	Yes

Precertification/notification coverage requirements for behavioral health		
Service	Precertification required for in-network provider?	Precertification required for out-of-network provider?
Supported Housing Enhanced Supported Housing		
Behavioral Health Crisis Services		
Mobile Crisis Services	No	Yes
Crisis Respite	No	Yes
Crisis Stabilization	No	Yes
Home Health Care	Yes	Yes
Psychological/Neuropsychological Testing	Yes	Yes
Injectable Drugs	No	Yes
Electroconvulsive Therapy	Yes	Yes
Emergency Room Services	No	No
Court-ordered Services	Yes	Yes
Transportation, Nonemergency For Medically Necessary Treatment	Yes	Yes

Note: For any inpatient or outpatient behavioral health services that are not covered by contract, precertification is needed.

Wellpoint precertification requirements by procedure code are searchable through our Precertification Look-up Tool online at: provider.wellpoint.com/tennessee-provider/resources/precertification/precertification-lookup

Inpatient reviews

Inpatient admission reviews

All inpatient hospital admissions, including urgent and emergent admissions, should be requested within 24 hours or the next business day for authorization. For those providers participating in the ADT (admission, discharge, transfer) Program, Wellpoint is notified in real time when a member is admitted to an inpatient facility for an urgent admission. Our Utilization Review clinician determines the member's medical status through communication with the hospital's Utilization Review department. Appropriateness of stay is documented, and a medical necessity review is initiated utilizing MCG CARE Guideline criteria. Cases may be referred to our medical director who renders a decision regarding the coverage of hospitalization based on medical necessity criteria. Discharge planning begins on member's admission and may result in coordination with our Case Management (CM) and Long-Term Services and Supports (LTSS) programs.

If members have behavioral health (BH) questions, they can access the BH department at 833-731-2153 (TTY 711) and follow the respective prompts. If there is a crisis, they are prompted on the front end to enter 9.

Inpatient concurrent review
Each network hospital will have an assigned Wellpoint UM clinician. The UM clinician will conduct a review of the supporting clinical information using the appropriate MCG Care Guidelines to determine if medical necessity has been met for an in-patient stay. If unable to make a determination, the request will be sent to the medical director for review and final determination. Clinical information may be provided via EHR access, electronically (i.e., fax, secure email), Availity Portal or telephone to the UM clinician. When the clinical information received meets medical necessity criteria, an authorization will be communicated to the hospital for the stay. The UM clinicians will also conduct a continued stay review as indicated using updated clinical information provided by the facility.

Wellpoint will authorize a covered length of stay based on the clinical information that supports the continued stay. Exceptions to the length of stay authorization are made for confinements when the severity of the illness and subsequent course of treatment is likely to be several days or is predetermined by state law. Exceptions may also be made by our medical director. Examples of confinement and/or treatment include the following but not limited to:

- Critical Care Unit
- Behavioral health inpatient or residential treatment
- C-section or vaginal deliveries

If the medical director determines the request does not meet medical necessity based on review of the appropriate criteria, a notice of adverse determination or denial letter will be faxed to the provider and mailed to the member. The facility is notified of the determination telephonically or electronically.

Discharge planning

Discharge planning begins on admission. The Wellpoint UM clinician or discharge planner will help coordinate discharge planning needs with the hospital utilization review staff and attending physician. The UM clinician or discharge planner will assist in making the appropriate referrals (i.e., Case Management (PH or BH), LTSS CHOICES or ECF CHOICES, Condition Care, Home Health). The attending physician is expected to coordinate with the member's PCP regarding follow-up care after discharge. The PCP is responsible for contacting the member to schedule all necessary follow-up care. In the case of a behavioral health discharge, the attending physician is responsible for ensuring that the member has secured an appointment for a follow-up visit with a behavioral health provider to occur within seven calendar days of discharge.

When long-term care is necessary, Wellpoint works with the provider, member and significant other to help plan the member's discharge to an appropriate setting for extended services. These services can often be delivered in a non-hospital facility such as a:

- Hospice facility.
- Skilled nursing or convalescent facility.
- Home health care program (e.g., home I.V. antibiotics).

When the provider identifies medically necessary and appropriate services for the member, Wellpoint will assist the provider and the discharge planner in obtaining a timely and effective transfer to the next appropriate level of care.

In the case of a behavioral health discharge, the following minimum requirements should be incorporated and documented in all discharge plans for inpatient and residential treatment:

1. Discharge planning beginning at admission.
2. Involvement of member, family (if appropriate), treatment team and the Wellpoint UM care manager/any active case managers, as appropriate, in the discharge planning process.
3. Seeking collateral information from established outpatient providers, if applicable, and referring back to established providers.
4. Ensuring adequate/appropriate housing on discharge, equivalent to living situation prior to admission.
5. Coordinating medical and behavioral health services as necessary.
6. Evaluating for additional treatment needs post-discharge. If patient is to be discharged to outpatient care, ensuring follow-up with Tennessee Health Link or Intensive Community Based Treatment Provider is scheduled to occur within seven calendar days of discharge if appropriate.
7. Notifying Wellpoint care management staff of a pending discharge in accordance with the Grier Consent Decree.
8. Upon discharge, contacting the Wellpoint UM care manager with the following information:

- Confirmation of the date of discharge
- Member's home address and phone number
- Discharge diagnoses/clinical disposition
- Current medications
- Aftercare plans (include agency name and telephone number of Tennessee Health Link or Intensive Community Based Treatment provider if appropriate, other outpatient appointment date/time)

Discharge plan authorizations follow individualized medical necessity criteria and documentation guidelines based on service(s) requested (refer to Precertification Look-Up Tool on Wellpoint Provider Portal). Authorizations include transportation, home health, Durable Medical Equipment (DME), follow-up visits to practitioners or outpatient procedures.

Emergency services

Wellpoint provides 24 hours a day, 7 days a week Nurse Helpline service (833-731-2153 [TTY 711]) with clinical staff to provide triage advice, referral and, if necessary, to make arrangements for treatment of the member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies. Emergency medical services are available at any available emergency care facility 24 hours a day, 7 days a week (including services outside the usual service area).

Wellpoint does not discourage members from using the 911 emergency system or deny access to emergency services. Emergency services are provided to members without requiring precertification. Emergency services coverage includes services that are needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as 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:

- 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
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency response is coordinated with community services, including the police, fire and EMS departments, juvenile probation, the judicial system, child protective services, chemical dependency services, emergency services, and local mental health authorities if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of, or in collaboration with, a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Wellpoint will compensate the provider for the screening, evaluations and examination that are reasonable and calculated to assist the health care provider determine whether the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Wellpoint. If the emergency department is unable to stabilize and release the member, Wellpoint will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network once notified. All transfers from non-network to network facilities are to be conducted only after the member is medically stable, and the facility is capable of rendering the required level of care.

If the member is admitted, notify us to request an authorization for the inpatient admission within 24 hours of admission or next business day. A Wellpoint review nurse will implement the review process. Medical necessity criteria will be applied based on the severity of illness and intensity of service.

If members have BH questions, they can access the BH department at 833-731-2153 (TTY 711) and follow the respective prompts.

Urgent care

Although Wellpoint requires its members to contact their PCP in situations where urgent, unscheduled care is necessary, precertification with Wellpoint is not required for a member to access a participating urgent care center.

16. QUALITY MANAGEMENT

Quality Management program

Overview
Wellpoint maintains a comprehensive Quality Management/Quality Improvement (QM/QI) program to objectively monitor and systematically evaluate the care and service provided to members. The scope and content are to comply and coordinate QM program activities with applicable state and federal regulations, the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and/or the Accreditation Association for Ambulatory Health Care (AAAHC) Accreditation standards while reflecting the demographic and epidemiological needs of the population served. We inform members and practitioners annually about the QM/QI program, and they have opportunities to make recommendations for areas of improvement. The QM/QI program goals and outcomes are available upon request to providers and members, and studies are planned across the continuum of care and service with proactive evaluation and refinement of the program.

This initial program development is based on reviewing the needs of the specific population we serve. Systematic re-evaluation of those needs occur on an annual basis. This includes not only age/sex distribution and language and specialized needs, but also a review of utilization data (i.e., inpatient, emergent/urgent care and office visits by type, cost and volume). This information defines high-volume or problem-prone areas.

There is a comprehensive committee structure in place with oversight from Wellpoint. This structure includes traditional committees, such as a peer review committee and credentialing committee, community/member/provider advisory committees for CHOICES and ECF CHOICES services, and a Medical Advisory Committee (MAC) for practitioner engagement and feedback. In addition, there are informal opportunities for provider engagement and feedback, via town halls, individual meetings or Patient-Centered Medical Home and Tennessee Health Link Collaboration meetings.

Practitioners and providers must allow Wellpoint to use performance data in cooperation with our QI program and activities. Pursuant to Section 5.1 of the provider contract, performance data includes access to medical records including but not limited to HEDIS® reporting and other reports aimed at improving clinical outcomes. Wellpoint is included in the reference of applicability to state and federal agency access.

Providers will permit Wellpoint or its designated agent to review records directly related to services provided to covered persons, by making records available to Wellpoint onsite at a provider's facility upon reasonable notice from Wellpoint and during regular business hours, participation in Electronic Medical Record (EMR) transmission programs or providing Wellpoint associates direct access into the provider or provider groups EMR. Providers must obtain all necessary releases, consents and authorizations to permit Wellpoint access to Wellpoint members' medical records. Providers must also supply one copy of the records described above to Wellpoint at no charge upon request. This would include performance data in cooperation with the Wellpoint QI program and activities, and

access to medical records for HEDIS reporting and other reports aimed at improving clinical outcomes. Subsequent requests or medical records will be at the provider's current charge.

Quality Management Committee

The purpose of the Quality Management Committee (QMC) is to maintain quality as a cornerstone of Wellpoint culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the QM program.
- Establish processes and structure that ensure accreditation compliance.
- Review planning, implementation, measurement and outcomes of clinical and service QI studies.
- Coordinate communication of QM activities throughout the health plans.
- Review HEDIS and CAHPS® data and action plans for improvement.
- Review and approve the annual QM/QI program description, work plans for each service area and evaluation.
- Provide oversight and ensure compliance delegated services.
- Provide oversight and review of subordinate committees.
- Review and approve the annual UM program and reports
- Review and approve the annual Population Health program description.
- Work plans for each service area and evaluation.
- Ensure full integration of CHOICES and ECF CHOICES members in all aspects contained within the QI program, including reporting, analysis and interventions designed to improve overall health and wellbeing.
- Ensure practitioner involvement through direct input from Medical Advisory Committees or other mechanisms that allow practitioner involvement.
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities.

Medical Advisory Committee (MAC)

The purpose of the MAC is to:

- Provide applicable advice and input to the corporate committee with oversight over the development and updating of Clinical Practice Guidelines (CPGs).
- Solicit advice regarding aspects of health plan policy and operations affecting network providers or members.
- Assess the levels and quality of care provided to members.
- Recommend, evaluate, and monitor minimum standards of care for members.

- Provide guidance and feedback regarding technology assessments.

A TennCare Medical Director is invited as a guest and receives notice of the meetings no fewer than 10 days prior to the meeting date.

The MAC's responsibilities are to:

- Review and provide input, based on characteristics of the local delivery system, including clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization.
- Review clinical study results and develop action plans/recommendations regarding clinical QI studies.
- Review and provide input to clinically-oriented health plan policies and procedures.
- Support a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk, and problem-prone conditions.
- Utilize an ongoing peer review system to assess levels of care and quality of care provided; consider and act in regard to physician sanctions.
- Monitor practice patterns in order to identify appropriateness of care and to improve risk prevention activities.

Peer review activities performed by the MAC are legally protected from discovery. The MAC is considered a peer review body as defined by the Healthcare Quality Improvement Act and Tennessee Peer Review Stature (Tennessee Code Annals §63-1-150. Applicability; Quality Improvement Committee; record confidentiality; discovery; liability).

Credentialing Committee

The purpose of the Credentialing Committee is to credential and recredential all participating practitioners according to health plan, state, federal and accreditation standards and to consider or act in regard to practitioner sanctions. The Credentialing Committee conducts review for all providers who apply for participation in the plan and reviews all participating providers for recredentialing purposes, including the review of any quality or utilization data and reports.

Clinical Services Committee

The purpose of the Clinical Services Committee (CSC)is to bring multidisciplinary leaders together to address over-and-underutilization management that present significant challenges and/or risks to the organization. The CSC also identifies opportunities to improve services and clinical performance based on a review of demographic and epidemiologic information targeting high-volume, high-cost, high-risk and problem-prone conditions.

Detail Responsibilities:

- Provide oversight of and monitor all Clinical Operations functions ensuring effectiveness of clinical programs and compliance with regulatory requirements
- Monitor over and under utilization

- Annual review of Utilization Management (UM) and Care Management (CM) Program Descriptions and Evaluations
- Clinical Practice Guidelines
- Clinical Criteria for UM Decisions
- Review of UM and CM Policies and Procedures ensuring compliance with Federal, State and NCQA requirements and standards

Quality of care
All physicians, nurse practitioners, physician assistants (PA), and other contracted facilities and ancillary providers are evaluated for compliance with pre-established standards as described in the Wellpoint credentialing program. We monitor and evaluate individual practitioner performance in the areas of health care quality and service, administration, and member satisfaction and provide appropriate feedback and remediation of individual findings when needed. Quality review of individuals may result in significant interventions depending on severity including termination from the network, reporting to state licensing agencies, the National Practitioner Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB).

Review standards are based on medical community standards, external regulatory and accrediting agencies requirements, and contractual compliance. Reviews are accomplished by appropriate personnel who strive to develop relationships with practitioners and providers that will positively impact the quality of care and services provided to our members.

Our quality program includes review of quality of care issues identified for all care settings. Staff use member complaints, reported adverse occurrences (i.e., "never events"), potential quality of care or service issues, and other information to evaluate the quality of service and care provided to our members.

Claim submission and adjudication procedures

Secondary non-billing provider requirements
Effective June 1, 2017, all secondary/non-billing Medicaid providers (e.g., referring, rendering, ordering, etc.) must be registered with TennCare during the claims date of service. If not, the claim will reject or deny. This is for both participating and nonparticipating providers.

Medication Therapy Management Pilot (MTM)
For specific information on the requirements that need to be met to bill for MTM services, please see the *MTM Provider Operations Manual*, which can be found at tn.gov/tenncare/providers/managed-care-contractors/pharmacy-benefits-manager/medication-therapy-management-pilot-program.html.

Medication Therapy Management Program
Reimbursement for MTM services will cover a per month case rate that includes an initial face- to-face, one-on-one visit with the TennCare member. Follow-up monthly case rate visits may be done

face-to-face or indirectly (i.e., telephonically) at the member's preference. Initial case rate is based on a minimum of at least 15 minutes per month.

As part of MTM pilot reporting and tracking, the pharmacist must use professional claim (CMS-1500) for billing MTM services and utilize the required CPT codes to submit for MCO reimbursement. It is important for participating pharmacists to submit the following CPT© code(s) to identify the MTM service in conjunction with the service modifier (case rate) to properly receive reimbursement payments.

Participating pharmacists provide MTM under a collaborative practice agreement (CPA) with a TennCare Patient Centered Medical Home (PCMH) or Tennessee Health Link (THL)

Medication Therapy Management (MTM) Reimbursement Guidelines: The Case Rates for MTM Covered Services are described below:

Service Description	Modifier Code	Payment Limits	Units
Targeted Disease States (Juvenile Asthma or Diabetes)	U1	2 Months	1 unit for each case rate
Medium-High Risk	U2	3 Months	1 unit for each case rate
Critical, High Risk	U3	6 Months	1 unit for each case rate
Exceptions (Requires appropriate approval)	U4	Limit based on appropriate approval	1 unit for each case rate
Moderate Risk	U5	2 Months	1 unit for each case rate

The below CPT codes will be used to indicate the services the member received:

CPT Code	CPT Code Description
99605	Medication therapy management service(s) provided by pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; new patient visit, initial 15 minutes
99606	Medication therapy management service(s) provided by pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; established patient visit, initial 15 minutes
99607	Add-on code for each additional 15-minute increment

98966	Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical
98967	Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical
98968	Telephone assessment and management service provided by a nonphysician qualified health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

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 98966, 98967, or 98968.

Pharmacist must complete and upload an MTM exception (ME) form to the CCT for any service limit exceptions. Claims submitted beyond the risk-based maximum limit as described in this section may be subject to recoupment unless -an MTM exception (ME) form is received. The MCOs will review the ME form for completeness to determine reimbursement appropriateness based on the guidelines provided by TennCare. Upon billing, the U4 modifier is to be addressed on the claim as the second modifier. The pharmacist might need to submit MTM exception form to each MCO subject to MCO requirements.

Non-Physician Medical Practitioners
Allied Professionals to include non-physician practitioners commonly referred to as midlevel practitioners are reimbursed in accordance with the applicable methodology for the contracted Fee Schedule. If the Fee Schedule is Wellpoint Professional Provider Market Master Fee Schedule, the applicable state methodology on which such fee schedule is based on shall be used to determine the appropriate level of reimbursement. Wellpoint follows the CMS non-physician practitioner claim

reimbursement methodology. All non-participating practitioners, including midlevel practitioners require an authorization.

Practitioner Emergency Department Reimbursement
The following guidelines apply when determining Emergency Department (ED) methodology for practitioner providers:

1. If the provider bills CPT codes 99281-99285 and the claim meets ED criteria, the Participating (PAR) provider is reimbursed in accordance to their Wellpoint contract. Nonparticipating (NonPar) providers are reimbursed the equivalent reimbursement as a Par provider in accordance with TennCare rule 1200-13-13-08(2) (no less than 80% of the lowest paid rate by Wellpoint to an equivalent Par provider for the same service).
2. Effective July 1, 2011, if the provider bills with CPT codes 99281-99285 and the claim does not meet defined ED criteria, PAR providers are reimbursed a maximum of $50 or their contracted reimbursement, whichever is less. NonPar providers are reimbursed a maximum of $50 or the equivalent PAR provider contracted amount, whichever is less in accordance with TennCare rule 1200-13-13-.08(2). The respective claim's Explanation of Payment (EOP) will provide an explanation code of "ERC" – DX billed does not meet ER criteria".

Facility Emergency Department Reimbursement
The following guidelines apply when determining ED reimbursement methodology for facility providers:

1. Emergency services do not require prior authorization or primary care physician referral and are provided for emergency services needed to screen and/or stabilize emergency physical/behavioral health conditions found to exist using the prudent layperson standard regardless of the final diagnosis or whether these services are provided by a contract or noncontract provider.
2. If the facility is contracted on levels for ED services and a non-emergent diagnosis code is in box 67 or 70A, claims will be paid at the lowest-level emergency room level contracted rate (99281) or billed charges, whichever is less.
3. If the facility is contracted with non-emergent ED rates and a non-emergent diagnosis code is in box 67 or 70A, claims will be paid at the non-emergent contracted rate or billed charges, whichever is less.
4. If the facility is contracted other than on levels of with a non-emergent ED rate and a non-emergent diagnosis is in box 67 or 70A, claims will be paid at the Emergency Medical Treatment and Labor Act (EMTALA) calculated rate (revenue code 0451/CPT 99281) per the contract. The revenue code 0451/CPT 99281 rates will be calculated and paid regardless of the service billed. No additional ancillary services will be paid.
5. If the facility bills only a screening charge (revenue 0451), the claim will be paid regardless of the primary diagnosis or presenting symptom in accordance with CRA A.2.7.1.3. The payment for a screening is all-inclusive, and no additional ancillary services will be paid.

CLIA requirements

Background: Wellpoint implemented *Clinical Laboratory Improvement Amendments (CLIA)* requirements for claims with dates of service on or after September 15, 2019, for *CLIA* certification validation. Our system reads directly from the CMS Provider of Service (POS) *CLIA* file to validate *CLIA* information. CMS updates this file every three months. To ensure your claims process correctly and the POS files are current, we strongly advise that providers proactively submit an updated *CLIA* certificate three months prior to the *CLIA* certification expiration date.

Laboratory procedures are only covered and, therefore, payable if rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code or does not have complete servicing provider demographic information will be considered incomplete and rejected or denied. Please note: All out of network providers require an authorization.

The CLIA certification must be effective for the claim date of service. The address registered with CMS for the CLIA certificate billed on the claim must also match either the billing or servicing address submitted on the claim. Providers that have applied and been approved by CMS as multi-site providers are excluded from address validations.

Providers who have obtained a *CLIA Waiver* or Provider Performed Microscopy Procedure accreditation must include the QW modifier for *CLIA* waived laboratory service when reported on a *CMS-1500* claim form in order for the procedure to be evaluated to determine eligibility for benefit coverage.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same CMS-1500 claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Claim submission requirements
Professional service and independent laboratory providers are required to include a valid *CLIA* number on all claims submitted for laboratory services, including *CLIA*-waived tests. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	*CLIA* number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly *HCFA-1500*), paper claim	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the address is not equal to the billing provider address. The servicing or billing provider address must match exactly to the address associated with the *CLIA* ID entered in field 23.
HIPAA 5010 837 professional, electronic claim	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address. The servicing or billing provider address must match exactly to the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

- This is an example of valid *CLIA* number format: 19DXXXXXXX.
- The first three characters are the two-digit state code followed by the letter D.
- The remaining seven digits are the unique *CLIA* system number assigned to the provider.
- Do not add the letters CLIA to the 10-character *CLIA* number.

Claim rejection/denial reason codes:

- GLI — Valid *CLIA* number must be submitted if the *CLIA* number is missing or invalid.
  - *B85 - CLIA* is not valid for claim dates of service.
  - B84 - CMS CLIA address does not match. The CMS address for *CLIA* does not match exactly to the address in box 32 or 33 of the *CMS-1500* form.
- GLJ — CLIA number invalid for services:
  - This denial code is applied to the claim line if the provider is billing for services that are beyond the scope of this *CLIA* certification level.

- Z71 — QW modifier (all of the following must apply):
  - The provider has a Certificate of Waiver CLIA level. o The service billed requires a QW modifier per current CMS list of waived codes. o The provider did not bill the QW modifier as required per CMS.

Tennessee payment reform initiatives

Beginning in 2021, Tennessee implemented a newly designed health care reform initiative based on value and outcome-based reimbursement models. This system rewards high-quality care and outcomes and encourages clinical effectiveness.

According to CRA Section A.2.13.1.9, providers will adhere to the retrospective episode-based reimbursement and Primary Care Transformation strategies, inclusive of Patient Centered Medical Home and Tennessee Health Link, consistent with Tennessee's multi-payer payment reform initiative in a manner and on a timeline approved by TennCare. This includes:

- Using a retrospective administrative process to reward cost and quality outcomes for the initiative's payment reform strategies that is aligned with the models designed by TennCare.
- Implementing key design choices as directed by TennCare including the definition of each episode and the definition of quality measures for the initiative's payment reform strategies.
- Delivering performance reports for the initiative's payment reform strategies with same appearance and content as those designed by the State/Payer coalition.
- Implementing payment reform strategies at a pace dictated by the state; for episodes, this is approximately three to six new episodes per quarter with appropriate lead time to allow payer and provider contracting.
- Participating in a state-led process to design and launch new episodes including the seeking of clinical input from payer medical teams and clinical leaders throughout Tennessee.

Wellpoint is required by CRA Section A.2.13.1.10 to implement state budget reductions and payment reform initiatives including retrospective episode-based reimbursement as described by TennCare.

Electronic submission

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

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)

- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

Availity's EDI submission Options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – Availity.com > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

EDI Response Reports
All claims submitted to Availity will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at 800-AVAILITY (800-282-4548).

If submitting claims using single claim submission on Availity Essentials, the EDI management role is required to review your response reports.

Payer ID
Claim Payer ID: WLPNT

Note: If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.

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:

1. Log in to Availity apps.availity.com/availity/web/public.elegant.login
2. Select My Providers
3. Select 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.

Use EnrollSafe (enrollsafe.payeehub.org/) to register and manage EFT account changes.

Visit provider.wellpoint.com/tn/claims/electronic-data-interchange for EFT registration instructions.

EDI Submission for Corrected Claims

For corrected electronic claims:

- Use frequency type (7) - Replacement of Prior Claim
- Submit original claim number for the corrected claim

EDI segments required:

- Loop 2300- CLM - Claim frequency code
- Loop 2300 - REF - Original claim number

Please work with your vendor on how to submit corrected claims.

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

Paper claims submission

Providers also have the option of submitting paper claims. Paper claims must be submitted on original red claim forms in black and white, laser printed or typed in a large, dark font. The time frames for submitting and Wellpoint receiving an original Institutional *UB-04/CMS-1450* or *Professional CMS-1500 (02-12) Claim* form must be 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. A corrected claim or replacement claim may be submitted within 120 calendar days of payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date that the third-party documents resolution of the claim. For cases of retroactive eligibility, the time frames for filing a claim will begin on the date that Wellpoint receives notification from TennCare of the member's eligibility/enrollment.

Please make sure that corrected claims are marked appropriately and submitted separately for each member and episode of care. If a corrected claim is not appropriately marked the claim may be processed as a new claim and may deny for timely filing or as a duplicate claim. Please ensure that the words "Corrected" or "Corrected Claim" are printed on each page of the claim in blue or black ink. Make certain that claims with multiple pages are labeled accordingly (e.g., 1 of 3, 2 of 3, etc.). Please note that corrected claims cannot be accepted by batch, bulk, or packaged submissions. That is, one cover letter or claim that is stamped "corrected" cannot represent the status of the claims that follow; each corrected claim must be labeled individually and accompanied by the appropriate *Provider Payment Dispute and Correspondence* form. This will help ensure that your claim and correspondence are scanned, interpreted, and processed efficiently.

For additional information or if you have any questions, please contact our EDI Hotline at 800-590-5745.

CMS-1500 (02-12) and *UB-04 CMS-1450* must include the following:

- Patient's ID number
- Patient's name
- Patient's date of birth
- Diagnosis code/revenue codes
- Date of service
- Place of service
- Resubmission code (when applicable)
- Procedures, services or supplies rendered
- CPT-4 codes/HCPC codes/DRGs with appropriate modifiers if necessary
- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- Wellpoint provider number
- NPI number of billing, attending and rendering provider when applicable
- State Medicaid ID number
- COB/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician when applicable
- NPI number of referring physician when applicable
- Any other state required data

You can access the *CMS-1500* form and completion instructions at: cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html.

Wellpoint cannot accept claims with alterations to billing information. Wellpoint does not accept computer-generated or typewritten claims with information that is marked through, handwritten, or whited out. Claims that have been altered will be returned to the provider with an explanation of the reason for the return.

Behavioral health practitioners must use the appropriate modifier associated with their licensure for CPT codes:

Service description	Billing code	Modifier
Psychiatrist/M.D.	CPT	–
Licensed psychologist/Ph.D.	CPT	HP
Licensed master's clinician	CPT	HO
Clinical nurse specialist	CPT	SA

Paper claims must be submitted to the following address:

Wellpoint
TN Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Use Availity Essentials platform for claim submissions, claim status inquiries, member eligibility and benefits information:

Availity.com
800-AVAILITY (800-282-4548)
Support@availity.com

International classification of diseases, 10th revision (ICD-10) description

As of October 1, 2015, ICD-10 became the code set for medical diagnoses and inpatient hospital procedures in compliance with *HIPAA* requirements, and in accordance with the rule issued by the U.S. Department of Health and Human Services (HHS).

ICD-10 is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes. In the United States, the codes are the foundation for documenting the diagnosis and associated services provided across healthcare settings.

Although we often use the term ICD-10 alone, there are two parts to ICD-10:

- Clinical modification (CM): ICD-10-CM is used for diagnosis coding
- Procedure coding system (PCS): ICD-10-PCS is used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States

ICD-10-CM replaces the code sets ICD-9-CM, volumes one and two for diagnosis coding, and ICD-10-PCS replaces ICD-9-CM, volume three for inpatient hospital procedure coding.

National drug code reporting requirements

Federal and state guidelines mandate the inclusion of National Drug Code (NDC) codes on all claims with provider-administered drugs, and Wellpoint will edit claims for these NDC codes. This requirement originated from the Federal Deficit Recovery Act of 2005.

Any claim received by Wellpoint with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code, unit of measure and quantity in the appropriate format (as explained below) will be rejected and will need to be corrected and resubmitted as a new claim. Also, all paper claims submitted with provider-administered drugs must use the *CMS-1500 (02-12) Claim* form. You can access the new *CMS-1500 (02-12)* form at cms.hhs.gov.

Professional claims that are submitted via EDI (837P) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit for measurement code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug's NDC code in the shaded area of Form Locator 24A for each applicable claim line. Form Locator 24A must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code (11 digits, no dashes) in the shaded area. The codes must be 11 digits in a 5-4-2 format. That is, the first five digits identify the manufacturer of the drug and are assigned by the FDA. The remaining digits are assigned by the manufacturer and identify the specific product and package size. Some packages will display less than 11 digits, but leading zeroes can be assumed and need to be used when billing. See below for further details. You must also include each drug's 2-digit NDC unit of measure and numeric quantity administered to the patient in the shaded area following the NDC code of Form Locator 24A for each applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ML-Milliliter, UN-unit or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal, and three numbers may follow the decimal.

NDC 5-4-2 formatting for 10 digit NDC codes:
XXXX-XXXX-XX = 0XXXX-XXXX-XX – Submitted as 0XXXXXXXXXX
XXXXX-XXX-XX = XXXXX-0XXX-XX – Submitted as XXXXX0XXXXX
XXXXX-XXXX-X = XXXXX-XXXX-0X – Submitted as XXXXXXXXX0X

Below is an example of reporting NDC information on a CMS-1500 paper form:

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. #
N45914801665 UN1													N	1B	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

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. #
N44950267230 UN1 50.00													N	1B	12345678901
10	01	05	10	01	05	11		J7603		1	50 00	2.5	N	NPI	0123456789

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at 800-590-5745 or VA1Claims@wellpoint.com for assistance.

NDC reporting requirements for facilities (*837I/CMS-1450* form)

Federal and state guidelines mandate the inclusion of NDC codes on all claims with provider-administered drugs, and Wellpoint will edit claims for these NDC codes.

The Federal Deficit Recovery Act of 2005 contains requirements for all state Medicaid agencies to obtain certain claim information (including NDC, unit of measure, quantity and unit price) for all provider-administered drugs except inpatient services, radiopharmaceuticals (unless billed separate from the related procedure) and vaccines. Wellpoint will edit claims to ensure that all 837I electronic claims or *CMS-1450* paper claims include this required information. This drug information is required on all Medicaid-related claim forms, even if Medicaid is a secondary or tertiary payer.

Any institutional claim received by Wellpoint with a Healthcare Common Procedure Coding System (HCPCS) code for a provider-administered drug (generally a J-code) that does not include the applicable NDC code and other quantity and pricing information in the appropriate format (as explained below) will be denied and will require additional information for reconsideration.

Each J-code submitted must have a corresponding NDC on each claim line. If the drug administered is comprised of more than one ingredient (e.g., compound drugs, same drug different strengths, etc.), each NDC must be represented. For the same drug with different strengths, the J-code should be repeated as necessary to cover each unique NDC. For compound drugs, each NDC should be represented via repeating the appropriate NDC or utilizing the compound drug section of the claim, depending on what is appropriate for the claim form.
A valid NDC must be used on all J-code drugs. To be considered valid, an NDC must be present in the correct field, in the correct format, using the 5-4-2 *HIPAA* standard 11-digit code, and be found on TennCare's drug file.

Institutional claims that are submitted via EDI (837I) should include applicable NDC codes in Loop 2410, LIN03 segment. In addition, providers must submit the NDC Quantity in Loop 2410, CTP04 and the unit of measure code in Loop 2410, CTP05-01.

All paper claims with provider-administered drugs must include each drug's NDC code in Form Locator 43 for each applicable claim line. Form Locator 43 must have the NDC qualifier N4 followed immediately (no spaces) by the NDC code. The NDC codes must be 11 characters (5-4-2 format as required by *HIPAA* guidelines with zeros or asterisks acting as placeholders), so it will be necessary to look up the 5-4-2 format code if something different is printed on the drug packaging.

You must also include each drug's two-digit NDC unit of measure and numeric quantity administered to the patient in Form Locator 43 with a space between the NDC number and the NDC unit of measure for each applicable claim line. There are five valid units of measure qualifiers that can be used (F2-International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-unit, or ME-Milligram). If reporting a fraction of a unit, use the decimal point. Nine numbers may precede the decimal and three numbers may follow the decimal.

Should you have any questions on proper NDC formatting and submissions, please contact our EDI Helpdesk at 800-590-5745 or VA1Claims@wellpoint.com for assistance.

Here are some examples for the *UB-04 CMS-1450* paper form:

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATE/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	
1	0259	N400025016608 UN3	J3490	041207	3	13 00	1
2	0450	EMERGENCY ROOM	99282	041207	1	360 00	2
3	0636	N465174*84021 ML1	J1270	041207	4	11 12	3
4	0636	N4125162791*3 ML12.5	J2916	041207	10	47 50	4
5							5

Medical Coding
The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout Wellpoint. Those guidelines include, but are not limited to:

- Correct modifier use Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements Analysis of codes, code definition and appropriate use

Wellpoint uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary.

Reimbursement by Code Definition
Wellpoint allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state, federal or CMS contracts and/or requirements.

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Encounter data

Wellpoint has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Wellpoint for each member encounter. Encounter data can be submitted through EDI submission methods or on a *CMS-1500 (02-12) Claim* form unless other arrangements are approved by Wellpoint. Data will be submitted in a timely manner but no later than 90 days from the date of service.

The encounter data will include the following:

- Member ID number
- Member name (first and last name)
- Member date of birth
- Provider name according to contract
- Wellpoint provider number
- Coordination of benefit information
- Date of encounter

- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider Tax ID number and state Medicaid ID number

Encounter data should be submitted to the following address:

Wellpoint
TN Claims
Virginia Beach, VA 23466-1010

Through claims and encounter data submissions, HEDIS information is collected. This includes the following:

- Preventive services (e.g., childhood immunization, mammography and Pap smears)
- Prenatal care (e.g., LBW and general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by our utilization and quality improvement staff, coordinated with the medical director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in provider termination.

Claims adjudication

Wellpoint is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims that are submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the *CPT-4* and *ICD-10 Manuals*. Hospital facility claims should be submitted using the *UB-04 CMS-1450* and provider services using the *CMS-1500*.

Providers must use *HIPAA*-compliant billing codes when billing Wellpoint. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Wellpoint will not pay any claims submitted using noncompliant billing codes.

Wellpoint reserves the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

Claims with diagnosis-related group (DRG) outlier charges will require an itemized bill to substantiate the outlier payment. If an itemized bill is not submitted with the claim, Wellpoint will pay the contracted DRG amount only, deny the outlier charge(s) and request an itemized bill through an explanation code on the *Explanation of Payment* (*EOP*). The explanation code will be “GMU”.

To avoid a split claim, when a provider submits one claim that contains more than one form, the

provider should not total each page. The provider should enter "CONT'D" in fields 28, 29 and 30. We also request the provider add page 1 of 2, 1 of 3, etc. if possible.

For claims payment to be considered, providers must adhere to the following time limits:

- Claims must be received at Wellpoint within 120 days from the date the service is rendered or for inpatient claims filed by a hospital within 120 days from the date of discharge.
- In the case of other insurance, Wellpoint must receive the claim within 120 days of other insurance *EOP* date.
- Claims for members whose eligibility has not been added to the state's eligibility system must be received within 120 days from the date the eligibility is added, and Wellpoint is notified of the eligibility/enrollment.
- A corrected claim or replacement claim may be submitted within 120 calendar days of Wellpoint payment notification (paid or denied). Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.
- Claims, including corrected claims, received after the applicable filing deadlines will be denied.

After filing a claim with Wellpoint, you may review your *EOP*. If the claim does not appear on an *EOP* within 15 business days as adjudicated or you have no other written indication that the claim has been received, check the status of your claim at provider.wellpoint.com/tn or call Provider Services at 833-731-2154. If the claim is not on file with Wellpoint, resubmit your claim so it is received within the applicable filing time limit for an original or corrected claim. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

Clean claims adjudication

A clean claim is a request for payment for a service rendered by a provider that:

- Is timely submitted by a provider.
- Is accurate.
- Is submitted on a *HIPAA*-compliant standard claim form including a *CMS-1500 (02-12)* or *UB-04 CMS1450* or successor forms thereto or the electronic equivalent of such claim form.
- Is a complete claims submission following any and all *HIPAA* compliance standards (Levels 1-7).
- Includes NPI and taxonomy information for rendering, attending, and billing providers.
- Includes, for all J-codes billed, NDC code and drug pricing information (NDC quantity, unit price and unit of measurement) are required. Exceptions are:
  - Vaccines for children which are paid as an administrative fee.
  - Inpatient administered drugs.
  - Radiopharmaceuticals unless the drug is billed separately from the procedure.
- Requires no further information, adjustment, or alteration (including written information or substantiation) by a provider in order to be processed and paid by Wellpoint.

Ninety percent of clean claims are adjudicated within 30 days and 99.5 percent within 60 days of receipt of a clean claim.

Paper or Wellpoint website claims that are determined to be unclean will be returned to the billing provider along with a letter stating the reason for rejection for those claims submitted on paper. Electronic claims (EDI) that are determined to be unclean will be returned to a Wellpoint contracted clearinghouse and, in turn, will be reported out to either the billing provider or the vendor the billing provider used to submit the claim.

Wellpoint produces and mails an *EOP* 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.

Disclosure of ownership

All contracted providers are required to register with TennCare and provide their disclosure information. TennCare collects this information when a provider registers/re-verifies with them and sends a file to us on a weekly basis as the authorized source of disclosure information. During the initial credentialing process, we verify the provider's information is in the state file before submitting any application or contract to be completed. If the provider is not in the state DOO file, the credentialing department will contact the provider to ensure he or she registers.

If an existing provider has not registered with TennCare and is not listed on the state file, we will give 120 days from the date of service on the claim for the provider to register with TennCare and reprocess the claim. A provider is required to re-attest/revalidate every three years with TennCare. Failure to register/revalidate with TennCare will result in termination from the Wellpoint network.

17. Claims

Claims status

Providers can check the status of claims at provider.wellpoint.com/tn or call Provider Services at 833-731-2154 to check claims status. Providers should also use the claims status response reports available for claims that were electronically submitted through a clearinghouse for information on accepted and rejected claims.

Wellpoint supports the ability to obtain real time claim status information using the 276/277 transaction through Smart Data Solutions. Providers interested in utilizing this functionality can contact Smart Data Solutions directly at 855-297-4436 to obtain additional information.

Reimbursement Policies

These reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if Wellpoint covered the service for the member's benefit plan. The determination that a service, procedure, or other item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Wellpoint may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. Wellpoint strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Reimbursement Hierarchy

Claims submitted for payment must meet all aspects of criteria for reimbursement. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity/clinical

criteria, authorization requirements and/or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered conditions of payments.

Review Schedules and Updates to Reimbursement Policies
Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to a Wellpoint business decision. We reserve the right to review and revise our policies when necessary. When there is an update, we will publish the most current policies to our provider website.

Outlier reimbursement audit and review process — requirements and policies

This section includes guidelines on reimbursement to Providers and Facilities for services on claims paid by DRG with an outlier paid at percent of billed charge or when the entire claim is paid at percent of billed charge. Our vendor-partner or our internal team may review these claims as part of our itemized bill review (IBR) program to ensure appropriate reimbursement. Upon completion of the review, documentation, including a summary of adjusted charges, will be provided for each claim. Disputes related to the review may be submitted according to the instructions in the Claims Payment Disputes section of this manual.

In addition to any header in this section, please refer to all other service specific sections which may have more stringent guidelines. There may be multiple sections that apply to any given reimbursable service.

Audits/records requests
At any time, a request may be made for on-site, electronic or hard copy medical records, utilization review documentation and/or itemized bills related to Claims for the purposes of conducting audit or reviews.

Blood, Blood Products, and Administration

Blood and blood products such as platelets or plasma are reimbursable. Administration of blood or blood products by nursing/facility personnel are not separately reimbursable on inpatient claims. Administration of blood or blood products by nursing/facility personnel billed on outpatient claims are separately reimbursable when submitted without observation/treatment room charges.

Charges for blood storage, transportation, processing, and preparation such as thawing, splitting, pooling, and irradiation are also not separately reimbursable. Lab tests such as typing, Rh, and matching are separately reimbursable charges.

Courtesy Room
Courtesy Room means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Members. Wellpoint will not separately reimburse for Courtesy Room charges.

Emergency room supplies and services charges
The Emergency Room level reimbursement includes all monitoring, equipment, supplies, and time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services. See Facility Personnel Charges and Nursing Procedures sections for additional information.

Facility personnel charges
Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), therapeutic, prophylactic, or diagnostic intravenous (IV) injections or infusion or IV fluid administration/monitoring, call back charges, nursing increments, therapy increments, bedside respiratory and pulmonary function services, and chemotherapy infusion/administration/monitoring. Charges for Outpatient Services for facility personnel are also not separately reimbursable and are included in the reimbursement for the procedure or Observation charge.

Implants
Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure.

Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants. Implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member will not be reimbursed.

IV sedation and local anesthesia
Charges for IV sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, are not separately reimbursable and are included as part of the Operating Room (OR) time/procedure reimbursement. Charges for Medications used for IV sedation and local anesthesia are separately reimbursable.

Lab charges
The reimbursement of charges for specimen collection are considered facility personnel charges and the reimbursement is included in the room and board or procedure/Observation charges. Examples include venipuncture, urine/sputum specimen collection, draw fees, phlebotomy, heel sticks, and central line draws.

Processing fees, handling fees, and referral fees are considered included in the procedure/lab test performed and not separately reimbursable.

Labor care charges
Reimbursement will be made for appropriately billed room and board or labor charges. Payment will not be made on both charges when billed concurrently.

Nursing procedures
Fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed Facility personnel (technicians) performed during an inpatient (IP) admission or outpatient (OP) visit will not be reimbursed separately. Examples include, but are not limited, to therapeutic, prophylactic, or diagnostic intravenous (IV) injections or infusion or IV fluid administration/monitoring, intramuscular (IM) injections, subcutaneous (SQ) injections, nasogastric tube (NGT) insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, pulse oximetry, etc.), inpatient blood transfusion administration/monitoring and inpatient chemotherapy infusion/administration/monitoring (with the exception of OP blood administration, OP chemotherapy administration, or OP infusion administration which are submitted without a room charge, observation charges, or procedure charges other than blood, chemotherapy, or infusion administration.)

Operating room time and procedure charges
The operating room (OR) charge will be reimbursed on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room
- The services of qualified professional and technical personnel
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

Personal care items and services
Personal care items used for patient convenience are not separately reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste.

Pharmacy charges
Pharmacy charges will be reimbursed to include only the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy

personnel. All other services are included in the drug reimbursement rate. Examples of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees, IV diluents such as saline and sterile water, IV Piggyback (IVPB), Heparin and saline flushes to administer IV drugs, and facility staff checking the pharmacy ("Rx") cart.

Portable charges
Portable Charges are included in the reimbursement for the procedure, test, or x-ray, and are not separately reimbursable.

Pre-operative care or holding room charges
Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure and are not separately reimbursed. In addition, nursing care provided in the pre-operative care areas will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

Preparation (set-up) charges
Charges for set-up, equipment, or materials in preparation for procedures or tests are included in the reimbursement for that procedure or test.

Recovery room charges
Reimbursement for recovery room services (time or flat fee) includes all used and/or available services, equipment, monitoring, and nursing care that is necessary for the patient's welfare and safety during his/her confinement. This will include but is not limited to cardiac/vital signs monitoring, pulse oximeter, medication administration fees, nursing services, equipment, supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery room services related to IV sedation and/or local anesthesia
Separate reimbursement will not be made for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II or step-down recovery room (e.g., arteriograms).

Respiratory Services

Mechanical Ventilation / CPAP / BIPAP support and other respiratory and pulmonary function services provided at the bedside are considered facility personnel, equipment, and/or supply charges and not eligible for separate reimbursement.

Routine Supplies and services
Any supplies, items, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Special procedure room charge
Charges for Special procedure room, billed ~~charges~~ in addition to the procedure itself, are included in the reimbursement for the procedure. If the procedure takes place outside of the OR (Refer to Operating Room Time and Procedure Charges for OR definition), then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Example: procedures performed in the ICU, ER, and others.

Stand-by charges
Stand-by equipment and consumable items which are on stand-by, are not reimbursable. Stand-by charges for facility personnel are included in the reimbursement for the procedure and not separately reimbursable.

Stat charges
Stat charges are included in the reimbursement for the procedure, test, and/or X-ray. These charges are not separately reimbursable.

Supplies and equipment
Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, isolation carts, mechanical ventilators, continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BIPAP) machines, and related supplies are not separately reimbursable. Oxygen charges, including but not limited to, oxygen therapy per minute/per hour when billed with room types ICU/CCU/NICU or any Specialty Care area are not separately reimbursable.

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

Telemetry
Telemetry charges in ER/ ICU/CCU/NICU or telemetry unit (step-down units) are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

Time calculation:

- Operating Room (OR): Time should be calculated on the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.
- Hospital/ Technical Anesthesia: Reimbursement of technical anesthesia time will be based on the time the patient enters the operating room (OR) until the patient leaves the room, as documented on the OR nurse's notes. The time the anesthesiologist spends with the patient in pre-op and the recovery room will not be reimbursed as part of the hospital anesthesia time calculation.
- Recovery Room: The reimbursement of Recovery Room charges will be based on the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit ("PACU") record.

- Post Recovery Room: Reimbursement will be based on the time the patient leaves the Recovery Room until discharge.

Undocumented or Unsupported Charges

Charges that are not documented on medical records or supported with documentation are not reimbursed.

Video or digital equipment used in procedures
Charges for video or digital equipment used for visual enhancement during a procedure ~~in a surgery~~ are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but not limited to Ultrasound and Fluoroscopy guidance including but not limited to, for access and/or placement of medical devices, implants, or lines. Charges for batteries, covers, film, anti-fogger solution, tapes etc., are also not separately reimbursable.

Additional reimbursement guidelines for disallowed charges
For any Claims that are reimbursed at a percent of charge, only Charges for Covered Services are eligible for reimbursement. The disallowed charges (charges not eligible for reimbursement) include, but are not limited to, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by your specific agreement. Please refer to your contractual fee schedule for payment determination.

The tables below illustrate examples of non-reimbursable items/services codes.

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0990 – 0999	Personal Care Items Courtesy/Hospitality Room Patient Convenience Items (0990) Cafeteria, Guest Tray (0991) Private Linen Service (0992) Telephone, Telegraph (0993) TV, Radio (0994) Non-patient Room Rentals (0995) Beauty Shop, Barber (0998) Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Stand-by Charges
0220, 0949	Add on Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedure
0270, 0271, 0272	Supplies and Equipment Blood Pressure cuffs/Stethoscopes Thermometers, Temperature Probes, etc. Pacing Cables/Wires/Probes Pressure/Pump Transducers Transducer Kits/Packs SCD Sleeves/Compression Sleeves/Ted Hose Oximeter Sensors/Probes/Covers Electrodes, Electrode Cables/Wires Oral swabs/toothettes; Wipes (baby, cleansing, etc.) Bedpans/Urinals Bed Scales/Alarms Specialty Beds Foley/Straight Catheters, Urometers/Leg Bags/Tubing Specimen traps/containers/kits Tourniquets Syringes/Needles/Lancets/Butterflies Isolation carts/supplies Dressing Change Trays/Packs/Kits Dressings/Gauze/Sponges Kerlix/Tegaderm/OpSite/Telfa Skin cleansers/preps Cotton Balls; Band-Aids, Tape, Q-Tips Diapers/Chucks/Pads/Briefs Irrigation Solutions ID/Allergy bracelets Foley stat lock

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	Gloves/Gowns/Drapes/Covers/Blankets Ice Packs/Heating Pads/Water Bottles Kits/Packs (Gowns, Towels and Drapes) Basins/basin sets Positioning Aides/Wedges/Pillows Suction Canisters/Tubing/Tips/Catheters/Liners Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) Preps/prep trays Masks (including CPAP and Nasal Cannulas/Prongs) Bonnets/Hats/Hoods Smoke Evacuator Tubing Restraints/Posey Belts OR Equipment (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, heparin and saline flushes, etc.)
0220 – 0222, 0229, 0250	Pharmacy Administrative Fee (including mixing meds) Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) Patient transport fees
0223	Utilization Review Service Charges
0263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy IV Infusion concurrent for therapy (96368) IV Injection (96374, 96379)

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy Medication prep Nonspecific descriptions Anesthesia Gases – Billed in conjunction with Anesthesia Time Charges IV Solutions 250 cc or less, except for pediatric claims Miscellaneous Descriptions Non-FDA Approved Medications (subject to UM determination- Medical Policies)
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Specimen collection Draw fees Venipuncture Phlebotomy Heel stick Blood storage and processing blood administration (Rev codes 0380, 0390 – 0392; 0399) Thawing/Pooling Fees

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, glucose, etc.)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment including rentals Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery Instrument Trays and/or Surgical Packs Drills/Saws (All power equipment used in O.R.) Drill Bits Blades IV pumps and PCA (Patient Controlled Analgesia) pumps Isolation supplies Daily Floor Supply Charges X-ray Aprons/Shields Blood Pressure Monitor Beds/Mattress Patient Lifts/Slings Restraints Transfer Belt Bair Hugger Machine/Blankets SCD Pumps Heal/Elbow Protector Burrs Cardiac Monitor EKG Electrodes Vent Circuit Suction Supplies for Vent Patient Electrocautery Grounding Pad Bovie Tips/Electrodes Anesthesia Supplies Case Carts C-Arm/Fluoroscopic Charge Wound Vacuum Pump and supplies Bovie/Electro Cautery Unit Wall Suction

Examples of non-reimbursable items/services codes	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
	Retractors Single Instruments Oximeter Monitor CPM Machines Lasers Da Vinci Machine/Robot
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse) Nursing care Monitoring Pre- or Post-evaluation and education IV sedation and local anesthesia if provided by same physician or procedure nurse Intubation/Extubation CPR
0410	Nursing/Respiratory Functions: Oximetry Respiratory assessment/vent management Medication Administration via Nebs, Metered dose (MDI), etc. Charges Postural Drainage Suctioning Procedure Respiratory care performed by RN
0940 – 0945	Education/Training

Provider reimbursement

In accordance with TennCare contractor risk agreement (CRA) section A.2.13.2.2, Wellpoint shall not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare.

Electronic Funds Transfer and Electronic Remittance Advice

Wellpoint offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can choose to receive Wellpoint payments electronically through direct deposit to their bank accounts. If providers choose to receive Wellpoint payment via EFT, they must contact one of our EFT/ERA vendors for enrollment. In addition, providers can select from a variety of remittance information options including:

- Electronic remittance advice presented online and printed in your location.
- *HIPAA*-compliant data file for download directly to your practice management or patient accounting system.
- Paper remittance printed and mailed by Wellpoint.

As a provider, you can gain immediate benefits by signing up for enrollSafe.

- Improve efficiency for free. Reduce processing errors. You pay nothing to use enrollSafe.
- Improve cash flow. Get payments electronically, improving cashflow.
- Reduce accounting expenses. Import ERAs/835s directly into practice management or health information systems, eliminating the need for manual entry.
- Payments to advices/vouchers. Reconcile electronic payments with advices/vouchers quickly and easily.
- Maintain control over bank accounts. Keep total control over the destination of claim payment funds. enrollSafe supports multiple practices and accounts.
- Manage multiple payers. Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts as desired.
- Increase access to information. Get faster access to adjudicated claim information and get more remittance details.
- Mailbox capability. Establish a mailbox for automated delivery of 835s and/or PDFs

To register for ERA/EFT, please visit our website at provider.wellpoint.com/tn.

PCP reimbursement
Wellpoint reimburses PCPs according to their contractual arrangement.

Specialty care provider reimbursement
Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Wellpoint.

Specialty care providers will obtain PCP and Wellpoint approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized by the PCP's referral or beyond the scope of self-referral permitted under this program.
Specialty care provider services will be covered only when there is documentation of appropriate notification or precertification, as appropriate, and receipt of the required claims and encounter information by Wellpoint.

Hospice
Effective July 1, 2018, there are no longer distinct Level 1 and Level 2 nursing facility rates in the state of Tennessee. The new blended rate will be loaded to the nursing facility Level 1 Medicaid ID.

Revenue code 0658 and procedure codes Q5003 or Q5004 should be used. The use of T codes will cause the claim to deny.

Hospices must report the NPI of any nursing facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice. As of July 1, 2018, the billing hospice provider must obtain the NPI for the facility where the patient is receiving care and report the facility's name, address, and NPI in box 80 of the *UB-04* claim form. If any of the three items are missing in box 80, the claim will deny. Box 80 contains four lines with a 19-character limit on line 1 and a 24-character limit on lines 2-4.

Patient liability information should be in box 39, 40 or 41 with value code 23 and the patient liability amount. If there is no patient liability amount, please enter $0. If patient liability is left blank, the claim will deny.

Providers should bill for date of death.

Routine care (revenue code 0651 with applicable HCPCS Q codes) will be reimbursed depending on the number of days the member is in hospice. The payment will be reduced beginning with day 61. These calculations are subject to the normal wage index.

SIA payment for hospice services will include revenue code 0551 with HCPCS code G0299 (RN) or revenue code 0561 with HCPCS code G0155. Reimbursement will have a max of four hours (in 15-minute intervals) or 16 units per day combined for both disciplines. These services will occur during the last seven days of life. Per CMS, the state period cannot span accounting years.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll within 60 days will continue with the current date/payment calculations.

Claims that are received for a member who has been disenrolled from hospice and elects to re-enroll outside of 60 days will restart routine care eligibility and day one for pricing.

Palliative care and physician charges
Services should be billed on a *CMS-1500* (professional) claim form.

For palliative care, the claim should include the appropriate required data including CPT codes, practitioner in box 24j and the hospice billing facility in box 33.

There are no benefit or lifetime maximum restrictions for palliative care.

Procedure for processing overpayments

Refund notifications may be identified by two entities, Wellpoint Cost Containment Unit (CCU) or the provider. The CCU researches and notifies the provider of an overpayment requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Wellpoint, CCU will notify the provider of the overpayment. The provider will have the option to submit a *Refund Notification Form* along with the refund check or have the overpayment offset from future claim payments. If a provider identifies the overpayment or returns the Wellpoint check, a completed *Refund Notification Form* specifying the reason for the return must be included. The claim information must be submitted with this form. This form can be found on the provider website at provider.wellpoint.com/tn. The submission of the *Refund Notification Form* will allow the CCU to process and reconcile the overpayment in a timely manner. If a *Refund Notification Form* is not available, the provider can submit the refund check with a letter. The letter should include the following:

- Provider name/contact,
- Contact number,
- Provider ID,
- Provider Tax ID
- Subscriber ID
- Member Name
- Member Account Number
- Date of Service
- Total Billed Charges
- Total Check Amount
- Claim number(s)
- Reason for refund or check return:
    - Received an Overpayment Notification Letter
    - Contract rate change
    - Duplicate payment
    - Incorrect member
    - Incorrect provider
    - Negative Balance
    - Other Health Insurance (OHI) / Third-party liability (TPL)
    - Payment error
    - Billed in error / adjusted charge
    - Or other reason

For questions regarding the refund notification procedure, please call Provider Services at 833-731-2154 and select the appropriate prompt. Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

Cost Containment Overpayment Disputes

As indicated in the Wellpoint refund request letter, provider overpayment refunds not received and applied within the timeframe indicated will result in claim recoupment from any claim the provider submits to Wellpoint.

Providers wishing to submit an overpayment dispute for a solicitated overpayment recoupment request, can submit their request via Availity, by mail or Fax.

The mailing address and fax number are:

Cost Containment - Disputes
PO Box 62427
Virginia Beach, VA. 23466-2437
Fax - 866-920-1874

The processing time once these documents are received is 30 days.

Providers submitting a refund check, should mail the refund to the address below and include a copy of the overpayment letter received, a list of claims are being refunded and the refund amount to be applied to each claim to:

Cost Containment
PO Box 933657
Atlanta, GA. 31193-3657

What does this mean for you?
The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. To avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA.

The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement and Recovery Act.

This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to beneficiaries.

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 effective as of December 1, 2021. Professional and facility claims with a date of service on or after December 1, 2021, 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
- 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 as of December 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.

Claim payment disputes – Post-Service Appeals

Provider claim payment dispute process
If you disagree with the outcome of a claim, you may begin the Wellpoint provider payment dispute process. The simplest way to define a claim payment dispute is when the claim is finalized but you disagree with the outcome.

Please be aware, there are three common claim-related issues that are not considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- Claim inquiry: a question about a claim, but not a request to change a claim payment
- Claims correspondence: when Wellpoint requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence-related materials are in the *Correspondence Section* of this Provider Manual.
- Member Benefit appeals (as defined in section 13, Medical Management): a pre-service appeal for a denied service. For these, a claim has not yet been submitted.

For more information on each of these, please refer to the appropriate section in this Provider Manual.

The Wellpoint provider payment dispute process consists of two internal steps and a third external step. You will not be penalized for filing a claim payment dispute, and no action is required by the member.

1. Claim payment reconsideration: This is the first step in the Wellpoint provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. Claim payment appeal: This is the second step in the Wellpoint provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal.
3. Regulatory complaint: The state of Tennessee supports an external review process if you have exhausted both steps in the Wellpoint payment dispute process but still disagree with the outcome. See the Independent Review section of this Provider Manual.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced or zero-paid claims.
- Postservice authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Services rendered by a provider that have a denied authorization on file.
- Duplicate claim issues.
- Retroeligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

* Timely filing issues: Wellpoint will consider reimbursement of a claim, which has been denied due to failure to meet timely filing if you can 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists. Please refer to Provider Manual for additional information regarding timely filing and good cause requests.

Claim payment reconsideration

The first step in the Wellpoint claim payment dispute process is called the reconsideration. The reconsideration is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider website within 365 calendar days from the date on the *EOP* (see below for further details on how to submit). Reconsiderations filed more than 365 calendar days from the *EOP* will be considered untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect. If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

We will send you our decision in a determination letter, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action Wellpoint intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider's right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the Wellpoint claim payment appeal process is a necessary requirement before requesting a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

Claim payment appeal

If you are dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter.

Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.
If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Wellpoint professionals.

Wellpoint will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

The claim payment appeal determination letter will include:

1. A statement of the provider's claim payment appeal request.
2. A statement of what action Wellpoint intends to take or has taken.

3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. A statement about how to submit a state fair hearing.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a claim payment dispute

We have several options when filing a claim payment dispute. They are described below:

- Verbal (reconsideration only): Verbal submissions may be submitted by calling Provider Services at

  833-731-2154.

- Website (reconsideration and claim payment appeal): Wellpoint can receive reconsiderations and claim payment appeals via the secure Provider Availity Payment Appeal Tool at Availity.com. Supporting documentation can be uploaded to the Availity Portal. You will receive immediate acknowledgement of your submission.
- Written (reconsideration and claim payment appeal): Written reconsiderations and claim payment appeals should be mailed along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:

  Provider Payment Disputes
  P.O. Box 61599
  Virginia Beach, VA 23466-1599

Submit reconsiderations on the *Reconsideration Form* located at: provider.wellpoint.com/tn.
Submit written claim payment appeals on the *Claim Payment Appeal* form located at: provider.wellpoint.com/tn.

Required documentation for claims payment disputes

Wellpoint requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal:

- Your name, address, phone number, email, and either your NPI or TIN
- The member's name and their Wellpoint or Medicaid ID number
- A listing of disputed claims, which should include the Wellpoint claim number and the date(s) of service(s)
- All supporting statements and documentation

If a claim has been denied for timely filing, the following are acceptable forms of documentation for payment reconsideration:

- *EOB* or *Explanation of Medicaid Benefits* from the primary health payer dated within 120 days of claim submission to Wellpoint
- Confirmation of denial from the health payer within 120 days of claim submission to Wellpoint

- Documentation regarding the provision of the member's health plan insurance information dated within 120 days of claim submission to Wellpoint
- Documentation proving Wellpoint contributed to the filing delay
- Electronic report that states Wellpoint accepted the claim
- Computer-generated activity report that shows the date an electronic claim was originally submitted to Wellpoint (an acceptable report must contain a patient name or identification number, the date of service, and an indication the original claim was submitted electronically and accepted by Wellpoint)
- Copy of accounts receivable or billing statement to member showing dates of bills if no other insurance

The following are not acceptable forms of documentation for timely filing payment reconsideration:

- Screenshots showing dates of a claim previously submitted to the health plan
- *CMS-1450* or *UB-04* with print date located in box 31 or box 86, respectively
- Electronic report stating the health plan has rejected the claim

Claim inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Our Provider Experience program helps you with claim inquiries. Just call 833-731-2154 and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team called the Provider Service unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim correspondence

Claim correspondence is different from a payment dispute. Correspondence is when Wellpoint requires more information in order to finalize a claim. Typically, Wellpoint makes the request for this information through explanation of payment (EOP) The claim or part of the claim may be denied, but it is only because more information is required to process the claim. Once the information is received, Wellpoint will use it to finalize the claim.

Sign up with Availity Essentials to submit Request for Additional Information (RFAI) attachments. When documentation is required to complete the claim finalization, a notification will be delivered to the Availity home page that will direct you to the Attachment New application. Locate the request and attach the requested document for immediate review.

The following table provides examples of the most common correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected claim(s) - Response Reports	Contact Availity Client Services at 800-282-4548 when your claim was submitted electronically but was never paid or was rejected. They are available to assist you with setup questions and help resolve submission issues or electronic claims rejections. If you use a Clearinghouse or third-party vendor, work with them to review the response report rejections to have the claim resubmitted correctly.
EOP requests for supporting documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills, and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP requests for medical records	Submit medical records digitally using Availity Essentials. Or submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit corrected claims electronically or use Availity Essentials: • Use frequency type (7) - Replacement of Prior Claim • Submit the correct original claim number for the corrected claim Submit a *Claim Correspondence Form* and your corrected claim to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599 Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received in a timely manner, a

Type of Issue	What Do I Need to Do?
	corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Wellpoint to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency room payment review	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence P.O. Box 61599 Virginia Beach, VA 23466-1599

Medical necessity appeals – Post Service

Post service medical necessity appeals refer to a situation in which an authorization for a service was denied but the service has been rendered. These payment disputes shall follow the same process as the claim payment disputes.

Independent review

If Wellpoint continues to deny the provider's claim(s) or if Wellpoint does not respond to the reconsideration request within the specified time frames, then the provider may file a written request with TDCI to submit the payment dispute to an independent reviewer.

The provider must include a copy of the written request for reconsideration with the request for an independent review. If the provider does not have a written contract with Wellpoint on the date the request is filed with TDCI, then the provider must also send TDCI payment satisfactory to TDCI to cover the fees incurred by the independent reviewer. This payment will be refunded to the provider if the provider is not ultimately required to pay the independent reviewer. Otherwise, the payment will be used to reimburse any entity that paid the independent reviewer. The provider will also furnish TDCI any other information needed by TDCI to process the provider's request.

The provider must file a request for independent review within 365 calendar days after:

- The date Wellpoint denies the claim.
- The date Wellpoint recoups the claim.
- The date Wellpoint fails to respond within the specified time frames.

Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible for independent review.

TDCI will use best efforts to refer an equal proportion of the total disputed payment claims to each independent reviewer. A provider may request, and TDCI may allow, the payment claims of a provider involving Wellpoint to be aggregated and submitted for simultaneous review by an independent reviewer when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The mere fact that a claim is not paid does not create a common substantive question of fact or law, unless the provider has received no remittance advice or other appropriate written or electronic notice from Wellpoint, either partially or totally denying a claim, within 60 calendar days of the receipt of the claim by Wellpoint and such claims regard a common substantive question of fact or law. The reviewer will, within 14 calendar days of receipt of the disputed claim or claims, request in writing that both the provider and Wellpoint provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer will request the provider and Wellpoint to identify all information and documentation that has been submitted by the provider to Wellpoint regarding the disputed claim or claims, and advise that the reviewer will not consider any information or documentation not received within 30 calendar days of receipt of the reviewer's request unless Wellpoint or the provider requests additional time to complete the investigation of independent review requests when a provider elected to aggregate his or her claims. Thereupon, the reviewer may grant Wellpoint or the provider an additional 30 calendar days. The reviewer will then examine all materials submitted and render a decision on the dispute within 60 calendar days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit, or the reviewer requests and receives an extension of time from TDCI to resolve the dispute. In reaching a decision, the reviewer will not consider any information or documentation from the provider that the provider did not submit to Wellpoint during that organization's review of the provider's disputed claim or claims.

Should the reviewer need assistance on a medical issue connected with the disputed claim or claims, then the reviewer will refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the Division of TennCare, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may respond to the request, refer the request to an independent contractor, or refer the request to the Division of TennCare for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one or more states in the United States. The appeals unit will provide a concise response to the request within 120 calendar days after receipt. If the appeals unit seeks the guidance of the Division of TennCare on whether a benefit is a covered service, then the Division of TennCare must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer will make a final decision within 30 calendar days of receipt of the appeals unit's response.

The reviewer will send Wellpoint, the provider and the TDCI TennCare Oversight Division a copy of the decision. Once the reviewer makes a decision requiring Wellpoint to pay any claims or portion thereof, Wellpoint will send the payment in full to the provider within 20 calendar days of receipt of the reviewer's decision.

Within 60 calendar days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not brought within 60 calendar days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be *de novo* without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching a decision, will be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party will be entitled to an award of reasonable attorney's fees and expenses from the non-prevailing party. Reasonable attorney's fees means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate and will not exceed 10% of the total monetary amount in dispute or $500, whichever amount is greater.

In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim.

Providers who are owned by state or local governmental entities will retain the statutory right of setoff if available. Judicial review of a reviewer's decision regarding a state or local governmental provider will be in the Chancery Court of Davidson County, and not in the Tennessee Claims Commission, unless the provider and Wellpoint have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act, compiled in title 12, chapter 4, part 7, does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although such a provider will be responsible for paying any appropriate attorney's fees and expenses awarded.

All costs associated with implementing these procedures will be paid by Wellpoint. However, the provider will reimburse Wellpoint the independent reviewer's fee within 20 calendar days of receipt of the reviewer's decision, if the reviewer finds that Wellpoint properly denied the claim being reviewed. If a provider fails to properly reimburse Wellpoint, the TDCI TennCare Oversight Division may prohibit that provider from future participation in the independent review process. The current fee associated with an independent review request is $750 (it may be subject to change at the State's discretion).

Providers who must reimburse Wellpoint the independent reviewer fee should send their check to:

Wellpoint
ATTN: Finance Department
22 Century Blvd., Suite 220
Nashville, TN 37214

Wellpoint will compensate the independent reviewer pursuant to their written agreement within 30 calendar days of the receipt by Wellpoint of the independent reviewer's bill for services rendered. If Wellpoint fails to pay any such bill for the independent reviewer's services, then the independent

reviewer may request payment directly from the state from any funds held by the state that are payable to Wellpoint.

Coordination of Benefits and Third-party Liability Resources

TennCare Program requirements will be followed when third party liability resources (including subrogation) coordination of benefits procedures are necessary. Wellpoint agrees to use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to members in the Wellpoint plan. Wellpoint and its providers agree that the Medicaid program will be the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicaid members.

Providers have an obligation to request third-party payer information for TennCare enrollees. Providers generally request third-party information from patients at the point of service and should bill the third party prior to billing Wellpoint.

When Wellpoint is aware of third-party resources prior to paying for a medical service, it will avoid payment by denying a provider's claim and redirecting the provider to bill the appropriate insurance carrier unless certain pay and pursue circumstances apply. If Wellpoint denies a claim for third party liability, the provider may verify other health insurance by visiting our provider website at provider.wellpoint.com/tn or by contacting our Provider Services department at 833-731-2154 (or 866-805-4589 for Medicare providers).

When processing claims previously paid by a third-party resource, Wellpoint first reviews the primary carrier's EOP, and then the claim is coordinated by using the primary allowed amount or the Wellpoint allowed amount, whichever is the lesser. Third-party liability claims submitted for secondary payment by Wellpoint without the primary carrier's EOP will be denied stating the member has other insurance.

Pay and pursue circumstances are:

- When the services are rendered to a child under the age of 21 who does not have Medicare, including preventive, EPSDT and pediatric care
- If the claim is for prenatal or postpartum care or if service is related to OB care
- If the billed designated behavioral health services are non-Medicare covered benefits
- If any service rendered to a child of an absent parent (i.e., primary coverage is through a noncustodial parent after a divorce)

For these types of services, Wellpoint will pay the claim and pursue reimbursement from the appropriate party.

In some situations, Wellpoint may not learn of the existence of a third-party payer until after it has made payment on the claim. In these situations, Wellpoint has several options for recovering claim payment. One option is the provider may refund payments he or she has received from Wellpoint.

Once a provider has refunded a payment received from Wellpoint, the provider may not resubmit another claim to Wellpoint for the same service furnished to the same member on the same date.

To return an overpayment to Wellpoint, a provider must complete a Refund Notification Form specifying the reason for the return.

The *Refund Notification Form* can be found at provider.wellpoint.com/tn. Under *Resources*, select Forms > Claims & Billing > Refund Notification Form.

All refunds along with a completed *Refund Notification Form* should be mailed to:

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

If the provider does not refund the payment, Wellpoint may recover its payment to the provider if the following conditions are met:

- The claim was for a service delivered to an adult aged 21 and older, unless the adult is a pregnant woman who is receiving prenatal care.
- Fewer than nine months have passed since the date of service when there is a commercial insurer involved and fewer than two years have passed since the date of service when Medicare is involved.

Wellpoint will distribute a refund request letter that includes the:

- Name of the provider
- List of claims or a reference to a remit advice date
- Reason for the overpayment
- Contact and policy information for the third-party resource
- Time frames for payment or appeal of the decision of Wellpoint
- Information about how to file an appeal
- Request that the provider bill the commercial insurance carrier or Medicare

If the provider agrees with the refund request letter, the requested amount should be returned to Wellpoint within 45 calendar days from the date of the letter. If the provider does not agree, an appeal can be filed within 45 calendar days from the date of the refund request letter. The provider will have an additional 30 days to provide supporting documentation for the appeal. Providers should include a copy of the denial from the primary insurance carrier, if available, in the appeal request.

Please note that regardless of the type of service rendered, if Wellpoint determines that a duplicate payment has been received for a service (i.e., the provider billed and received payment from both the

third-party insurance carrier and Wellpoint), Wellpoint has the right to recover the duplicate payment.

Medicaid Reclamation and Refunds for TennCare Providers
TennCare providers have an obligation to identify any available third-party liability (TPL) insurance for a particular enrollee and to bill that TPL insurance before billing TennCare. When you are paid by TennCare or Wellpoint prior to securing payment from the TPL insurance, your payments are subject to reclamation. If you then bill the TPL insurance and are notified your claim is being denied as a duplicate payment, you have an opportunity to get refunds of these payments from us or TennCare. The new TPL Policy can be accessed at tn.gov/content/dam/tn/tenncare/documents2/con09001.pdf.

If a member's third-party insurance denies your claim because payment has already been sent to TennCare, you may complete and submit TennCare's Provider Refund Request Form. You can find this form on the TennCare website at tn.gov/content/dam/tn/tenncare/documents/medicaidreclamation.pdf. For more detailed information on this process, see the TennCare Policy Manual.

If a member's third-party insurance denies your claim because payment has already been sent to us, you should contact your Wellpoint Provider Relations representative for assistance. For more detailed information on this process, see our Medicaid Reclamation Refund Request Form, which is available in the forms appendix of this manual and on our website at provider.wellpoint.com/tn.

Note: When you contact TennCare with a reclamation refund request, TennCare will only pay the Medicaid amount initially paid to you on behalf of the member by Wellpoint, not the third-party insurer's rate.

Billing Members

Overview
Before rendering services, providers should always inform members that the cost of services not covered by Wellpoint will be charged to the member.

A provider who chooses to provide services not covered by Wellpoint:

- Understands that Wellpoint only reimburses for services that are medically necessary, including hospital admissions and other services
- Obtains the member's signature on the Client Acknowledgment Statement specifying that the member will be held responsible for payment of services
- Understands that he or she may not bill for, or take recourse against, a member for denied or reduced claims for services that are within the amount, duration and scope of benefits of the Medicaid program

According to CRA language 2.6.7.5 and the TennCare policy N0: PRO-08-001 (Rev. 9), providers or collection agencies acting on the provider's behalf may not bill members for amounts other than applicable TennCare cost sharing responsibilities for covered services, including services that the state or Wellpoint has not paid for, except as permitted by TennCare rules and regulations and as described below.
Providers may seek payment from a member only in the following situations:

- If the services are not covered services and, prior to providing the services, the provider informed the member that the services were not covered. The provider must inform the member of the noncovered service and have the member acknowledge the information. If the member still requests the service, the provider will obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Wellpoint for the service that has been provided, the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided and if the provider informs the person that he or she will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills Wellpoint for the service the prior arrangement with the member becomes null and void without regard to any prior arrangement worked out with the member.
- If the member's TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing amounts must be refunded when a claim is submitted to Wellpoint because the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established (the monies collected will be refunded as soon as a claim is submitted and will not be held conditionally upon payment of the claim).
- If the services are not covered because they are in excess of a member's hard benefit limit, and the provider complies with applicable TennCare rules and regulations.

Wellpoint will require, as a condition of payment, that the provider accept the amount paid by Wellpoint or appropriate denial made by Wellpoint (or, if applicable, payment by Wellpoint that is supplementary to the member's third-party payer) plus any applicable amount of TennCare cost-sharing responsibilities due from the member as payment in full for the service. Except in the circumstances described above, if Wellpoint is aware that a provider, or a collection agency acting on the provider's behalf, bills a member for amounts other than the applicable amount of TennCare cost sharing responsibilities due from the member, Wellpoint will notify the provider and demand that the provider and/or collection agency cease such action against the member immediately. If a provider continues to bill a member after notification by Wellpoint, Wellpoint will refer the provider to the Tennessee Bureau of Investigation.

Wellpoint members must not be balance-billed for an amount above that which is paid by Wellpoint for covered services.

In addition, providers may not bill a member if any of the following occurs:

- Failure to timely submit a claim, including claims not received by Wellpoint
- Failure to submit a claim to Wellpoint for initial processing within the 120-day filing deadline
- Failure to submit a corrected claim within 120 calendar days of payment notification (paid or denied)
- Failure to dispute a claim within the 365-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the dispute process

Client Acknowledgment Statement

A provider may bill a Wellpoint member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Wellpoint as being reasonable and medically necessary for my care or that are not a covered benefit. I understand that Wellpoint has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Wellpoint medically necessary standards for my care or not a covered benefit."
Signature: _____
Date: _____

If the provider bills Wellpoint for noncovered services, the member cannot be billed, regardless of any written agreement with the member.

Wellpoint Website and the Provider Inquiry Line

Wellpoint recognizes that in order to provide the best service to members, you need accurate, up-to-date information. Wellpoint offers two methods of accessing claim status, member eligibility and authorization status 24 hours a day, 365 days a year:

- You can check the status of a claim anytime by logging in to Availity Essentials at Availity.com and selecting Claims & Payments > Claim Status
- Toll-free automated provider inquiry line: 833-731-2154

Our website provides a host of online resources, featuring our online provider inquiry tool for real-time claim status, eligibility verification and authorization status. Detailed instructions for use of the online provider inquiry tool can be found on our website.

Toll-free automated provider inquiry line (833-731-2154): for real-time member status, claim status and authorization status. This option also offers the ability to be transferred to the appropriate department for other needs such as requesting new authorizations, ordering referral forms or directories, seeking advice in case or care management, or obtaining a member roster. Detailed instructions on the use of the Provider Inquiry line are set forth below.
Follow these easy steps to access member status information:

1. Dial 833-731-2154. After saying your NPI number or your provider ID and TIN, listen for the prompt.
   - You can say member status, eligibility, or enrollment status.
2. Be prepared to say the member's Wellpoint number, ZIP code and date of service.
3. You can also search by Medicaid ID, Medicare ID or SSN.
   - Just say I don't have it when asked to say the member's Wellpoint number, then say the ID type you would like to use when prompted for it.
4. The system will verify the member's eligibility and PCP

Say another member to access another member's status
Say main menu to perform other transactions
Say representative to be transferred to a live agent
Or simply hang up if you are done

Follow these easy steps to review claim status:

1. Dial 833-731-2154 and listen for the prompt.

- At the main menu, say claims.
- You can get the status of a single claim or the five most recent claims.
- You can speak to someone about a payment appeal form or an EOP.

2. Be prepared to say the claim number or member number/date of service.

- If you don't have any of these, you can hear the five most recent claims by saying recent claims.

Say repeat to hear the information again
Say another claim
Say main menu to perform other transactions
Say representative to be transferred to a live agent
Or simply hang up if you are done

Follow these easy steps to review authorization status:

1. Dial 833-731-2154 and listen for the prompt

- At the main menu, say authorizations or referrals.
- Say authorization status to hear up to ten outpatient statuses or one inpatient authorization status.
- Say new authorization and be transferred to the correct department based on authorization type.
- Be prepared to say the member's Wellpoint number, ZIP code, date of birth and date of service.
- Say the admission date or the first date for the start of service in MM/DD/CCYY format.

Say repeat to hear the information again
Say another authorization
Say main menu to perform other transactions
Say representative to be transferred to a live agent
Or simply hang up if you are done.

18. MEDICAL RECORDS

Wellpoint requires medical records to be maintained in a manner that is current, detailed and organized, and that promotes effective and confidential patient care and quality review. Medical records are available in the event use and disclosure of the medical records is required by law for administrative, civil and/or criminal investigations and/or prosecutions.

Providers are required to maintain medical records that conform to professional medical practice standards and appropriate health management. A permanent medical record must be maintained at the primary care site for every member and be available to the PCP and other providers with whom the member has a treatment relationship.

Medical records shall be maintained or available at the site where covered services are rendered. Enrollees (for purposes of behavioral health records, enrollee includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the enrollees' medical records, and subject to reasonable charges, be given copies thereof upon request and to request that they be amended or corrected.

Providers are to have provisions for ensuring that, in the event a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care provider, the first provider does not charge the enrollee or the second provider for providing the medical records.

Medical record keeping practices are to be consistent with NCQA recommended standards for medical record documentation as follows:

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.
9. For patients 12 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance use disorder history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.

11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under - or overutilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.
18. Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date, or an appropriate history has been made in the medical record (for adults).
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.

The QM department may assess any provider's medical record documentation against the plan's clinical practice guidelines, state requirements, and HEDIS guidelines for outcome measures as needed, based on quality improvement outcomes, initiatives, and when there is a possible quality of care issue or trend identified. Assessments are performed to ensure the safety of members and compliance to standard clinical practice guidelines. The Behavioral Health department includes dedicated auditors that will perform routine reviews on all Contracted Opioid Buprenorphine Enhanced and Supportive Medication-Assisted Recovery and Treatment (BESMART) Providers against the TennCare required standards relevant to the TennCare Opioid BESMART Program Description (CRA A 2.11.4.1.1.1.2). Additionally, the Quality Management department will perform routine reviews on contracted primary care Providers on EPSDT exam compliance. QM representatives conduct these audits annually and utilize a standard tool to measure compliance. To ensure continuity in the assessment of provider compliance, QM representatives, and BESMART auditors must complete and pass an annual Interrater Reliability (IRR) test.

Contracted Opioid BESMART Providers must achieve an overall passing score of 80%. Any score below passing may require the provider to submit a corrective or quality improvement action plan for review and approval by the health plan. Primary Care Providers are expected to achieve a score of 85% or more to be considered in compliance with EPSDT standards.

Wellpoint medical record standards for the Opioid BESMART program (adopted based on state requirements) and EPSDT Program are as follows:

TN STATE OPIOID BESMART PROGRAM STANDARDS

Section I: Policy & Procedure	
1	The Provider has a defined policy and procedure for conducting a Controlled Substance Monitoring Data (CSMD) review each time and prior to prescribing, dispensing, or administering opiates and/or a controlled substance. The policy should also include guidance around documenting the process in each patient's clinical record.
2	Provider employs, contracts, or partners with a behavioral health counselor to provide psychosocial assessment, addiction counseling, individual counseling, group counseling, self-help and recovery support, and therapy for co-occurring disorders. The counselor should be independently licensed, have a master's degree, and if not independently licensed but with a master's degree they should be supervised by a licensed mental health provider (ex. LMSW supervised by LCSW)
3	Provider employs, contracts, partners, or shows effort towards, engagement with a Certified Peer Recovery Specialist (has certification through TDMHSAS) in the community for consumer education, treatment engagement, and recovery planning.
4	Provider employs, contracts, or partners with a local care coordination resource. (Members of the Provider's own staff may serve as a care coordinator.)
5	A Diversion Control Plan is in place including a plan for routine and random pill/film counts.
6	A written plan is in place to address medical emergencies including naloxone on-site.
7	A written plan is in place to address psychiatric emergencies including involuntary hospitalization.
8	A policy and procedure is in place to request from the patient a consent to release information to ensure continuity of care and address communications with other providers who are treating the member and with member's informal support system.
9	The provider has a written policy and procedure for conducting routine and random drug screenings.
10	Provider assesses member experience by collecting surveys with the following elements: Support received during treatment initiation; accessibility to 7-day behavioral and/or physical health availability; and ease of pharmacy services for MAT and ability to obtain both MAT and psychiatric medications. Surveys may be completed anonymously as long as it has been documented that a survey has been completed.
TeleMAT	
11	Evidence of a policy or procedure that uses clinical evidence to determine if a member is no longer a good candidate for teleMAT due to specific risk factors (e.g., concern for diversion). **TeleMAT data should be collected for informational purposes only and should not be included in scoring.**
12	Evidence of a plan that would outline how a teleMAT provider would handle emergencies that arise via telehealth (e.g., psychiatric emergency, medical emergency, member high relapse risk). **TeleMAT data should be collected for informational purposes only and should not be included in scoring.**
13	If TeleMAT is being utilized by this provider, the platform has been evaluated and meets all necessary standards (e.g., Non-public facing). **TeleMAT data should be collected for informational purposes only and should not be included in scoring.**
MEMBER BASED ASSESSMENT	
Section II: Initial Assessment	

TN STATE OPIOID BESMART PROGRAM STANDARDS

14	The Provider assures either by performing it her/ himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, the performance and documentation of initial screening for the diagnostic criteria of an opioid use disorder diagnosis as defined in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM Code) determining outpatient buprenorphine MAT program is the most appropriate level of care/treatment.
15	The Provider assures either by performing it her/himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a substance use patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.
16	The Provider assures either by performing it her/himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a psychiatric patient evaluation using standardized assessment and evaluation tools within 30 days of treatment initiation.
17	The Provider assures either by performing it her/himself or by assuring it is conducted in full or in part by another qualified professional within the system in which she/he is working, a full medical history and examination within 30 days of treatment initiation.
18	There is evidence that the Provider has discussed with the member about a referral to a Primary Care, Behavioral Health and/or Substance Abuse Specialist.
19	There is evidence that the patient was trained on the provider's policy concerning involuntary termination of treatment.
20	A Narcotic or Controlled Substance Agreement (explaining risk/benefit to achieve informed consent) is present in the clinical record.
	Section Score
Section III: Appointment Frequency	
	Skip Standards 21-23 if the patient is in the maintenance phase. Skip Standard 22 if patient is not receiving counseling services
21	A patient in the induction or stabilization phases of treatment has had: 1. Weekly provider appointment scheduled
22	2. Where appropriate*, received appropriate counseling sessions at least twice a month;
23	3. Had one (1) observed drug screen at least weekly
	Skip Standards 24-26 if the member is either in the Induction/ Stabilization, OR Maintenance phase for greater than one year, and complete standards 27-29. Skip Standard 25 if patient is not receiving counseling services.
24	A patient in the maintenance phase of treatment in first year has had: 1. Provider appointment at least every two (2) to four (4) weeks;
25	2. Where appropriate*, received counseling sessions at least monthly;
26	3. Had an observed random drug screen at least eight (8) times in 12 months of treatment
	Skip Standards 27-29 if the member is either in the Induction/ Stabilization, OR Maintenance phase for less than one year. Skip Standard 28 if patient is not receiving counseling services.
27	A patient in the maintenance phase of treatment for one (1) year or longer has had: 1. Have a scheduled provider appointment at least every two (2) months;
28	2. Where appropriate*, follow-up counseling sessions discussed and/or considered for member (monthly counseling sessions recommended)
29	3. Had an observed random drug screen at least four (4) times in 12 months of treatment
	Section Score

TN STATE OPIOID BESMART PROGRAM STANDARDS

Section IV: Service Delivery	
30	There is evidence in the clinical record of member receiving training and education on the following topics (Note: These may be documented once with initial establishment of care; training that occurred more than 2 years before audit was completed does NOT meet this criteria): (a) Treatment options, including detoxification, benefits/risks associated with each option;
31	(b) Risk of neonatal abstinence syndrome for all female patients of childbearing age (ages 15-44);
32	(c) Prevention and treatment of chronic viral illnesses, such as HIV and hepatitis C;
33	(d) Therapeutic benefits and adverse effects of treatment medication;
34	(e) Risks for overdose, and
35	(f) Overdose prevention and reversal agents.
36	There is evidence that the Controlled Substance Monitoring Database (CSMD) was queried each time and prior to a prescription being ordered (e.g. e-scribed/called in/written).
37	A psychosocial assessment was completed by a qualified professional within the patient's treatment team.
38	An individualized treatment plan was completed within 30-days of treatment initiation.
	Skip Standard 39 if the member was not in treatment for more than six months.
39	Member's individualized treatment plan was reviewed every six months.
40	The medication prescribed for the member reflects the preferred medication of buprenorphine/naloxone combination (as covered by the TennCare formulary) for induction as well as stabilization unless contraindicated and then the buprenorphine monotherapy has been prescribed if contraindicated.
	Section Score
Section V: Coordination of Care	
	Skip Standard 41 if patient is in the maintenance phase OR no care coordination services were needed OR if patient declined/refused consent to release information.
41	Where appropriate, a patient in the induction or stabilization phases of treatment received care coordination services weekly
	Skip Standard 42 if patient is in the induction or stabilization phase OR if there are no other members of treatment team OR if patient declined/refused consent to release information.
42	Where appropriate, a patient in the maintenance phase of treatment received care coordination services at least monthly
	Skip Standard 43-45 if not applicable (for example, counseling is in house (43) or MAT provider is a PCP (44)) OR if patient declined/refused consent to release information.
43	Where appropriate, evidence that care coordination with BH counselor or provider took place within 30 days of treatment initiation and at least every 3 months following. This can be with an internal or external provider.
44	Where appropriate, evidence that care coordination with Primary Care Provider (PCP) took place within 30 days of treatment initiation and at least annually.
45	Where appropriate, evidence that information was exchanged with specialist/surgeon/and/or OB/GYN (e.g., sent records, requested records, phone call, updates, etc.).

EPSDT EXAM STANDARDS

STD #	Standard
1	Comprehensive Health & Developmental History is present and includes Physical History, Mental Health Development History, and Dietary Practices.
2	Immunizations history is present with immunizations scheduled or given based on the most recent Advisory Committee on Immunization Practices (ACIP) schedule according to age and health history.
3	Comprehensive Unclothed Physical completed, including measurements (the child's growth shall be compared against that considered normal for the child's age and gender)
4	Age appropriate Developmental and Behavioral Screening completed during encounter.
5	Laboratory tests or Risk Assessment for necessity of Laboratory Test, according to age, is present.
6	Vision and Hearing Screening as appropriate for age is present.
7	Anticipatory Guidance (Health Education) provided for age.
8	Documentation of any concerns or questions from the member or member's parent or guardian
9	Documentation in the chart to indicate any EPSDT services have been refused or declined during the encounter, such as immunizations, labs, or unclothed exam.
10	As appropriate, evidence is present in the medical record for a referral to an appropriate medical or behavioral health provider.
11	Documentation is present the provider has assessed member for a dental home or completed a dentition risk assessment.
12	Appropriate coding for EPSDT visit for rendered services was used, including but not limited to any codes for vaccinations, assessments, screenings, and laboratory tests if administered during the encounter.

19. CONFIDENTIALITY

Confidentiality of Information

Wellpoint complies with all state and federal law regarding the privacy and security of protected health information and the confidentiality of individually identifying information of a member or that of his/her family member. In the event of a conflict among these requirements, Wellpoint will comply with the most restrictive requirement.

All material and information, regardless of form, medium or method of communication, provided to Wellpoint by the state or acquired by Wellpoint pursuant to the TennCare Contractor Risk Agreement (Agreement) will be regarded as confidential information in accordance with the provisions of state and federal law and ethical standards and will not be disclosed. All necessary steps will be taken by Wellpoint to safeguard the confidentiality of such material or information in conformance with state and federal law and ethical standards.

Utilization management, case management, population health, discharge planning, quality management and claims payment activities are designed to ensure that patient-specific information, particularly Protected Health Information (PHI) obtained during review is kept confidential in accordance with applicable laws, including HIPAA and the HITECH Act (A.R.R.A. Secs. 13001 et seq.). Information is used for the purposes defined above. Information is shared only with entities who have the authority to receive such information and only with those individuals within said entities who need access to such information in order to conduct utilization management and related processes.

Wellpoint ensures that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the performance of Wellpoint under this Agreement, whether verbal, written, tape, electronic or otherwise, will be treated as confidential information to the extent confidential treatment is provided under state and federal laws. Wellpoint will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and preservation of its rights in compliance with federal and state law.

All information as to personal facts and circumstances concerning members or potential members obtained by Wellpoint will be treated as privileged communications, held confidential, and not be divulged without the written consent of TennCare or the member/potential member, provided that nothing stated herein will prohibit the disclosure when allowed by federal or state law of information in a limited data set summary, statistical or other form which does not individually identify an individual member/patient or members of his/her family. The use or disclosure of information concerning members/potential members will be limited to purposes directly connected with the administration of this Agreement and will be in compliance with federal and state law.

Nothing in this agreement shall permit Wellpoint or the provider to share, use or disclose protected health information (PHI) in any form via any medium with any third party beyond the boundaries and jurisdiction of the United States without express written authorization from the state.

Providers must adhere to Section 5, Responsibilities of the PCP concerning confidentiality of information.

HIPAA and the HITECH Act Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), encompasses legislation intended to improve the portability and continuity of health benefits, ensure greater accountability in the area of health care fraud, ensure the privacy and security of individual protected health information, and simplify the administration of health insurance. The HITECH Act, as part of the American Recovery and Reinvestment Act of 2009, was enacted on February 17, 2009 to provide incentives to health care industry participants for the adoption of electronic health records, to set forth a federal data breach law, and to heighten and enhance the privacy and security regulations provided under HIPAA.

In accordance with HIPAA regulations and HITECH, Wellpoint will:

- Comply with requirements of the Health Insurance Portability and Accountability Act of 1996, including 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 to/from its providers, subcontractors, clearinghouses 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 this Agreement 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 and Wellpoint and between Wellpoint and its providers and/or subcontractors to a halt, if for any reason Wellpoint cannot meet the requirements of this Section, TennCare may terminate this Agreement.
- Ensure that PHI data exchanged between Wellpoint and TennCare is used only for the purposes of treatment, payment or health care operations. Wellpoint shall ensure that requests by and responses to health oversight agencies are in keeping with federal regulations. All PHI data not transmitted for these purposes or for purposes allowed under the federal HIPAA regulations will be de-identified to protect the individual member's PHI under the privacy and security rules.
- Ensure that disclosures of PHI from Wellpoint to TennCare will be restricted as specified in the HIPAA regulations and will be permitted for the purposes of: 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 TennCare from Wellpoint will be as permitted and/or required under the law.
- Report to TennCare immediately upon becoming aware of any use or disclosure of PHI in violation of this Agreement by Wellpoint, its officers, directors, employees, subcontractors or agents or by a third party to which Wellpoint disclosed PHI.

- Execute business associate agreements where required by law and 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 Wellpoint.
- Make available to TennCare members the right to amend their PHI data in accordance with the federal HIPAA regulations. Wellpoint will 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 10 calendar days of notice by TennCare to Wellpoint such information as in the possession of Wellpoint and is required for TennCare to make the accounting of disclosures required by 45 CFR 164.528. At a minimum, Wellpoint will provide 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
  - 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 Wellpoint, Wellpoint will within two business days forward such request to TennCare. It will be TennCare's responsibility to prepare and deliver any such accounting requested. Additionally, Wellpoint will institute appropriate record-keeping processes and procedures and policies to enable Wellpoint 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 TennCare and 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 Wellpoint acknowledges and promises to perform the following obligations and actions:
  - Use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI Wellpoint creates, receives, maintains or transmits on behalf of 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 TennCare agrees to use reasonable and appropriate safeguards to protect the PHI.
  - Agree to report to TennCare's privacy officer immediately upon becoming aware of any unauthorized use or disclosure of member PHI not otherwise permitted or required by HIPAA. Such immediate report will include any security incident of which Wellpoint becomes aware that represents unauthorized access to unencrypted computerized data and that materially compromises the security, confidentiality or integrity of member PHI maintained by

Wellpoint. Wellpoint will also notify TennCare's privacy officer within two business days of any unauthorized acquisition of member PHI by an employee or otherwise authorized user of the Wellpoint system.

- If feasible, return or destroy all PHI, in whatever form or medium (including any electronic medium) and all copies of an 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. Wellpoint will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement. Wellpoint will identify any PHI that cannot feasibly be returned or destroyed. Within such 30 days after the effective date of the termination, cancellation, expiration or other conclusion of the Agreement, Wellpoint will:
  - Certify on oath in writing that such return or destruction has been completed
  - Identify any PHI which cannot feasibly be returned or destroyed
  - 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 in addition to the terms and conditions of this Agreement and including 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/HITECH regulation requirements as needed to include: use and disclosure of data; de-identification of data; access according to the minimum necessary standard; accounting of disclosures; patients' rights to amend, access, request restrictions and confidential communications; and right to file a complaint and breach notification.
- 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 Wellpoint staff and maintain signed acknowledgements by staff of the Wellpoint HIPAA policies.
- Be allowed to use and receive information from TennCare where necessary for the management and administration of this Agreement consistent with the administration of the Medicaid Plan, or TennCare, and to carry out business operations.
- Be permitted to use and disclose PHI for the legal responsibilities of Wellpoint.
- Adopt the appropriate procedures and access safeguards to restrict and regulate access to and use by Wellpoint employees and other persons, including subcontractors, performing work for Wellpoint to have only minimum necessary access to individually identifiable patient data within Wellpoint.

- For members who are deceased, continue to protect related personally identifiable information for 50 years following the date of death.
- 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.
- Obtain a third party certification of its HIPAA standard transaction compliance 90 calendar days before the start date of operations, if applicable, and upon request by TennCare.

Wellpoint will track all security incidents as defined by HIPAA. Wellpoint will periodically report in summary fashion such security incidents.

In the event of a breach, Wellpoint will indemnify and hold TennCare harmless for expenses and/or damages related to the breach. Such obligations will include mailing notifications to affected members.

In accordance with HIPAA regulations, TennCare will adhere to the following guidelines:

- Make its individually identifiable health information available to enrollees 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 noncompliance as required by law
- Establish similar HIPAA data partner agreements with its subcontractors and other business associates

20. FRAUD, WASTE, AND ABUSE

TennCare defines fraud as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (see 42 CFR 455.2).

TennCare defines abuse as provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program (see 42 CFR 455.2).

Waste is the overutilization, underutilization, or other misuse of resources that result in unnecessary costs to the Medicaid program, such as providing services that are not medically necessary.

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose stricter penalties.

Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, we educate providers on how to prevent member and provider fraud by identifying the different types and by staging the first line of defense.

Examples of Provider Fraud, Waste, and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a PROVIDER (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of Provider (for example, the doctor(s) name(s), the hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility, if you have it
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events

- Summary of what happened

Examples of Member Fraud, Waste, and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (identification) card
- Relocating to out-of-service Plan area and not notifying us
- Using someone else's ID card

When reporting concerns involving a MEMBER include:

- The Member's name
- The Member's date of birth, Member ID, or case number if you have it
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

To help prevent fraud, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients/members and reviewing their records for prescription administration will help minimize drug fraud, waste, and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Wellpoint member identification card. It is the first line of defense against fraud. Wellpoint may not accept responsibility for the costs incurred by providers providing services to a patient who is not a member even if that patient presents a Wellpoint member identification card. Providers should take measures to ensure the cardholder is the person named on the card.

Every Wellpoint member identification card lists the following:

- Effective date of Wellpoint membership
- Date of birth of member
- Subscriber number (Wellpoint identification number)
- Carrier and group number (RXGRP number) for injectables
- Wellpoint logo
- Health plan name — Wellpoint
- PCP
- PCP telephone number
- PCP address
- If applicable, copays for office visits, emergency room visits and pharmacy
- Behavioral health benefit
- Vision service plan telephone number
- Wellpoint Member Services and 24-hour Nurse HelpLine telephone numbers

Presentation of a Wellpoint member identification card does not guarantee eligibility. Therefore, you should verify a member's status by inquiring online or via telephone. Online support is available for

provider inquiries at provider.wellpoint.com/tn and telephonic verification may be obtained on the automated Provider Inquiry Line at 833-731-2154.

Additionally, encourage members to protect their cards as they would a credit card, carry their Wellpoint member ID card at all times and report any lost or stolen cards to Wellpoint as soon as possible.

Understanding the various opportunities for fraud and working with members to protect their Wellpoint ID card can help prevent fraud. If you suspect fraud, you should report such suspected fraud to any of the following:

- Wellpoint
    - Special Investigations Unit (SIU) Hotline at 866-847-8247 for provider or member fraud
    - Visiting the SIU's fighthealthcarefraud.com education site; at the top of the page click "Report it" and complete the *Report Waste, Fraud and Abuse* form.
- Directly to the OIG or TBI:
    - Office of Inspector General (OIG) at 800-433-3982 for member fraud
    - Tennessee Bureau of Investigation (TBI) at 800-433-5454 for provider fraud
    - State of Tennessee Office of Inspector General website at tn.gov/finance/fa-oig.html
    - The TBI Medicaid Fraud Control Division at TBI.MFCU@tn.gov
- TennCare Office of Program Integrity
    - TennCare Office of Program Integrity at ProgramIntegrity.TennCare@tn.gov

No individual who reports violations or suspected fraud, waste or abuse is subject to retaliation by Wellpoint.

Investigation Process

Our Special Investigations Unit (SIU) reviews all reports of Provider or Member fraud, waste and abuse. If appropriate, allegations and the investigative findings are reported to all applicable state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with Provider fraud, waste or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send secure/trackable communications to the Provider documenting the issues and the need for improvement. Correspondence may include education or requests for recoveries or may advise of further action.
- *Medical record review*: We review medical records in context to previously submitted claims and/or to substantiate allegations.
- *Prepayment Review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may result in reduced payment on future claims and/or further legal action.

If you are working with the SIU all checks and postal correspondence should be sent to:

Special Investigations Unit
740 W Peachtree Street NW
Atlanta, Georgia 30308
Attn: investigator name, #case number

Instructions for sending paper medical records and/or claims when working with the SIU is found in correspondence from the SIU. If you have questions, contact your investigator. Delays for claim and/or medical record review, and ultimately resolution of an investigation may be delayed if SIU-supplied instructions are not followed. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

About Prepayment Review

One method we use to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers (Facilities or Professionals), or certain Claims submitted by Providers, may come to our attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider is an outlier compared to his/her/its peers.

Once a Claim, or a Provider, is identified as an outlier or has otherwise come to our attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the review results in a determination the Provider's action(s) may involve FWA, unless exigent circumstances exist, the Provider is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider is on prepayment review, the Provider will be required to submit medical records and any other supporting documentation with each Claim so the SIU can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation in accordance with this requirement will result in a denial of the Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, we may review coding, documentation, and other billing issues. In addition, one or more clinical utilization management guidelines may be used in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan Members.

The Provider will remain subject to the prepayment review process until the health plan is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from the network at the direction of the State.

Providers are prohibited from billing a Member for services the health plan has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or

billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider Agreement, proper billing procedures and state law. Providers also may appeal such a determination in accordance with applicable grievance and appeal procedures.

Acting on Investigative Findings

If, after investigation, the SIU determines a Provider appears to have committed fraud, waste, or abuse the Provider:

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including Provider termination
- Will be referred to other authorities as applicable and/or designated by the State
- The SIU will refer all suspected criminal activity committed by a Member or Provider to the appropriate regulatory and law enforcement agencies.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a Member appears to have committed fraud, waste or abuse or has failed to correct issues, the Member may be involuntarily dis-enrolled from our health care plan, with state approval.

Offsets. Wellpoint shall be entitled to offset claims and recoup an amount equal to any overpayments ("Overpayment Amount") or improper payments made by the health plan to Provider or Facility against any payments due and payable by the health plan to Provider or Facility with respect to any Health Benefit Plan under any contract with our company regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by the health plan that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount within the timeframe specified in letter notifying the Provider or Facility of the Overpayment Amount. If the Overpayment Amount is not received within the timeframe specified in the notice letter, the health plan shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Wellpoint to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider or Facility disagree with any determination, Provider or Facility shall have the right to appeal such determination under Wellpoint procedures set forth in this Provider Manual, on condition that that such appeal shall not suspend Wellpoint right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Wellpoint reserves the right to employ a third-party collection agency in the event of non-payment.

The Tennessee Bureau of Investigation Medicaid Fraud Control Division (TBI MFCD) is the state agency responsible for the investigation of provider fraud, waste and abuse in the TennCare program. Wellpoint will report suspected provider fraud, waste and abuse to TBI MFCD.

The Office of Inspector General (OIG) has the primary responsibility to investigate TennCare administration and member fraud, waste and abuse. Wellpoint will report suspected member fraud to the OIG. TennCare's Office of Program Integrity (OPI) is the State Medicaid Agency unit responsible for the prevention, detection, and investigation of alleged provider fraud, waste, and abuse of the TennCare program.

Wellpoint and its network providers are required to cooperate with all state and federal agencies, including TBI MFCD and OIG, in investigating or prosecuting fraud, waste and abuse. Cooperation includes providing, upon request, information, access to records and access to interview providers and/or their employees or consultants, including those with expertise in the administration of the TennCare program and/or in medical or pharmaceutical questions or in any matter related to an investigation. Providers must make available to the TBI MFCD and OIG any and all administrative, financial, and medical records related to the delivery of items or services paid for with TennCare funds. In addition, the TBI MFCD and OIG must be allowed access to the place of business and to all TennCare records maintained by providers during normal business hours. Under certain special circumstances, TBI MFCD and OIG may request after-hours admissions. Said records are to be provided at no cost to the requesting agency.

Wellpoint maintains a written fraud, waste and abuse compliance plan designed to prevent and detect abuse, waste and fraud in the administration and delivery of services to TennCare members. Wellpoint will report all suspected and confirmed fraud, waste and abuse to the appropriate agency including:

- Suspected fraud, waste and abuse in the administration of the TennCare program will be reported to TBI MFCD, OPI and/or OIG
- Confirmed or suspected provider fraud, waste and abuse will be immediately reported to TBI MFCD or OPI
- Confirmed or suspected member fraud, waste and abuse will be immediately reported to OIG

Wellpoint will use the Fraud Reporting Forms or such other form as may be deemed satisfactory by the agency to which the report is to be made.

Member or provider fraud reporting forms can be accessed at tn.gov/finance/fa-oig/fa-oig-report-fraud.html. You may also email TBI.MedicaidFraudTips@tn.gov or ProgramIntegrity.TennCare@tn.gov to report fraud, waste or abuse.
Wellpoint will promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud, waste and abuse. Unless preapproval is obtained from the agency to whom the incident was reported, or from another agency (designated by the agency that received the report) after reporting confirmed or suspected fraud, waste or abuse, Wellpoint will not take any of the following actions as they specifically relate to TennCare claims:

- Contact the subject of the investigation about any matters related to the investigation
- Enter into or attempt to negotiate any settlement or agreement regarding the incident
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident

Wellpoint will promptly provide the results of its preliminary investigation to the agency to which the incident was reported, or to another agency designated by the agency that received the report.

More information on identifying fraud and abuse is located at tn.gov/finance/fa-oig/fa-oig-fraud-info.html. Information on ways to report fraud and abuse is located at tn.gov/finance/fa-oig/fa-oig-report-fraud.html.

False Claims Act

Wellpoint requires its providers and affiliates to abide by federal and state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes provider compliance with Section of 6032 of the Deficit Reduction Act of 2005 through provider's education of its employees, contractors and agents on the Federal False Claims Act. Section 6032 of the Deficit Reduction Act of 2005 (DRA), effective January 1, 2007, requires all entities that receive $5 million or more in annual payments to establish written policies that provide detailed information about the Federal False Claims Act, the administrative remedies for false claims and statements, applicable state laws that provide civil or criminal penalties for making false claims and statements, the "whistleblower" protections afforded under such laws and the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

The DRA establishes liability for the following activities:

- Knowingly presenting or causing to be presented to an officer or employee of the United States and/or applicable state government a false or fraudulent claim for payment or approval
- Knowingly making, using or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the government
- Conspiring to submit a false claim or to defraud the government by getting a false or fraudulent claim allowed or paid
- Possessing, having custody of or controlling property or money used or to be used by the government and intending to defraud the government or to willfully conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt
- After being authorized to make or deliver a document certifying receipt of property used or to be used by the government and with the intent to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
- Knowingly buying or receiving as a pledge, obligation or debt public property from an officer or employee of the government or any person who lawfully may not sell or pledge the property
- Knowingly making, using or causing 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
- Knowingly makes, uses or causes to be made or used any false or fraudulent conduct, representation or practice in order to procure anything of value directly or indirectly from the government

The federal government may impose penalties in accordance with the *Code of Federal Regulations* which can be accessed at 28 CFR § 85.5. The government may reduce the damages if there is a finding that the person committing the violation reports it within 30 days of discovering the violation and if the person cooperates fully with the federal government's investigation and if there are no criminal prosecutions, civil or administrative actions commenced at the time of the report and the person reporting does not have any knowledge of any such investigations. The federal government via the OIG may also use administrative remedies for the submission of false statements and/or claims that include administrative penalties of not more than $5,000 per false claim as well as determine whether suspension or debarment from the health care program is warranted.

Any employee who is discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against in the terms and conditions of employment by an employer due to lawful acts done by the employee on behalf of him or herself or others in furtherance of an action under this section, including investigation for, initiation of, testimony for or assistance in an action filed or to be filed under this section, is entitled to all relief necessary to make the employee whole. Such relief will include reinstatement with the same seniority status such employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate court for the relief provided in the subsection.

In addition, Wellpoint also requires its providers and affiliates to abide by state laws and regulations governing the administration and operations of managed care entities within the health care program. This includes compliance with the Tennessee Medicaid False Claims Act (T.C.A. § 71-5-181 et seq.) which establishes liability for the following activities:

- Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent
- Presenting or causing to be presented to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program
- Making, using or causing to be made or used, a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state while knowing that such a record or statement is false
- Conspiring to defraud the state by getting a claim allowed or paid under the Medicaid program while knowing that such claim is false or fraudulent
- Making, using or causing to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or to transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false
- Knowingly applying for and receiving a benefit or payment on behalf of another person, except pursuant to the lawful assignment of benefits under the Medicaid program, and converting that benefit or payment to his or her own personal use

- Knowingly making a false statement or misrepresentation of material fact concerning the conditions or operation of a health care facility in order that the facility may qualify for certification or recertification required by the Medicaid program
- Knowingly making a claim under the Medicaid program for a service or product that was not provided

Tennessee False Claims Acts (Tennessee Code Annotated 71-5-181 through 71-5-185) specify that:

A person or entity who presents (or causes to be presented) a claim for payment under the Medicaid program, knowing such claim is false or fraudulent, or who makes, uses or causes to be made or used, a record or statement to get a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false, is in violation of the Tennessee and federal False Claims Acts, and is subject to federal and state civil penalties. The state civil penalty is not less than $5,000 and not more than $25,000, plus three times the amount of damages that the state sustains because of the act of that person or entity.

Pre-admission evaluation (PAE) is submitted to TennCare for purposes of establishing eligibility for reimbursement of long term services and supports (LTSS), including nursing facility (NF) services and home and community based services (HCBS) received as an alternative to NF services. When approved, a PAE may also result in approval of Medicaid institutional eligibility and in a capitation payment to the MCO, as well as payment of claims for physical and behavioral health, pharmacy and LTSS. It is therefore critical that the information submitted on a PAE is complete and accurate, and does not result in payments being inappropriately authorized to an MCO or to the NF or other health care providers.

One situation in which NFs could submit information to TennCare in violation of the False Claims Acts is submission of an NF PAE when a person has elected to receive hospice services in the NF. Hospice services are not LTSS. When a person has elected to receive hospice services in an NF, the NF is providing hospice room and board and not NF services. However, if a PAE is submitted for NF services with a Medicaid only payer date (MOPD) that Medicaid-reimbursed NF services will begin and the person meets NF level of care, a CHOICES capitation payment will be generated in error to the MCO, resulting in an overpayment and a violation of the False Claims Act. Further, the physician who certified the PAE may also be in violation of the False Claims Act, because he has certified medical necessity for NF services (which is required for approval of the PAE), when in fact, hospice services are being received.

NFs are therefore advised to NOT submit a PAE when a person has elected to receive hospice services in the NF. Another situation pertains specifically to the MOPD captured on the PAE application. This is the date that the facility certifies that Medicaid reimbursement for NF services will begin because the person has in fact been admitted to the facility and all other sources of reimbursement (including Medicare and private pay) have been exhausted. This date must be known (and not estimated) because it too may result in establishment of eligibility for LTSS and in many cases, eligibility for Medicaid, and in payment of a capitation payment as well as payments for Medicaid (including but not limited to LTSS) services received. To the extent that a facility submits an

MOPD that is incorrect, overpayments may be made to the MCO as a result of the NF's actions, resulting in a violation of the False Claims Act.

NFs are therefore advised to ensure that staff submitting PAEs on behalf of the facility enter a MOPD *only* when such date is known and confirmed. The MOPD does not have to be submitted at the same time as the PAE. If you don't know the MOPD when the PAE is submitted, leave it blank. The PAE will still be processed. You can come back and complete the MOPD once it is known; however, do not forget to come back and enter this date when it *is* known. If an MOPD is not entered, the person will not be enrolled into CHOICES, and you will not be reimbursed for NF services.

If anyone acting on behalf of your facility has submitted any of these types of information that has resulted in an overpayment being paid — to you or to an MCO or other health care provider — you have 60 days to return any overpayments you have received and complete these notifications so that appropriate adjustments can be made and potential violations can be avoided. (See §6402 of the Affordable Care Act).

In addition, an NF's failure to provide proper notification of a change in a resident's status may result in violations of these acts. This includes situations in which a resident discharges from the facility, or remains in the facility but elects to receive hospice benefits. In these cases, if the NF does not timely notify the MCO using the form and process established by TennCare (visit the TennCare LTSS website to view memo and form 9/13/10), TennCare will continue to pay a capitation payment to the MCO for LTSS when the person is no longer receiving such services, resulting in an overpayment. In many cases, this also results in the person's eligibility in the institutional category being extended in error, payments for physical and behavioral health and pharmacy services for which the person no longer qualifies.

NFs are therefore advised to immediately submit a CHOICES Discharge/Transfer/Hospice Form to the MCO anytime a TennCare CHOICES member is discharged from your facility or is no longer receiving NF services (including when a member elects to receive hospice). This includes:

- Transfers to another nursing facility
- Discharges to the hospital (even when return to the facility is expected)
- Discharges home, with or without HCBS
- Election of hospice services
- Upon a resident's death

The Discharge/Transfer/Hospice Form is to be completed by the discharging facility and sent to the member's MCO.
Please note that while a facility is contractually obligated to submit the form for transfers to another facility and such notification is very important in terms of coordinating care for the resident, failure to notify the MCO of a transfer would not result in a potential violation of the False Claims Acts. However, failure to submit the form for discharges and hospice elections will.

When a person admits to an NF specifically for purposes of receiving hospice (rather than NF services), the person may nonetheless qualify in an institutional eligibility category once they have been "continuously confined" in the facility for a period of at least 30 days. Because a PAE is not required and should not be submitted for hospice services, TennCare can't use the PAE to prospectively establish "continuous confinement." However, upon conclusion of a 30-day institutional stay, TennCare may apply institutional income standards in determining eligibility for Medicaid services, including hospice. TennCare will not authorize Medicaid payment for LTSS; nor will a person receiving hospice in the NF be enrolled into CHOICES, since hospice services are not LTSS. A copy of the Division's hospice benefit policy is available online on the TennCare website.

For persons receiving hospice in an NF, TennCare will determine patient liability. Facilities are obligated pursuant to federal law to collect patient liability for hospice patients receiving hospice in an NF, and to use such payments to offset the cost of room and board billed to the hospice agency.

A PAE should be submitted ONLY for persons seeking Medicaid reimbursement of NF (not hospice) services. If a patient admits to the facility for NF services, facilities continue to be advised to submit a PAE as soon as you determine that Medicaid reimbursement will be needed, but no later than 10 days after the requested effective date of reimbursement. As you know, the earliest date of Medicaid reimbursement for NF services is the date that ALL of the following criteria are met:

- Completion of the PASRR process
- Effective date of level of care eligibility by TennCare (i.e., effective date of the PAE), which cannot be more than 10 days prior to date of submission of the approvable PAE
- Effective date of Medicaid eligibility (in most cases, the date of financial eligibility application)
- Date of NF admission

If a person appropriately enrolled into CHOICES for receipt of NF services subsequently elects to receive hospice services, the facility should not withdraw the MOPD, nor should the facility attempt to withdraw the original PAE. The PAE and MOPD are required in order for the facility to be reimbursed for NF services received prior to hospice election. Rather, the facility must submit to the MCO a CHOICES Discharge/Transfer/Hospice Form so that overpayments will not be made to the MCO since the person is no longer receiving NF services. The person who has elected hospice will be disenrolled from CHOICES, but not from Medicaid, so long as he continues to receive hospice services in the NF. The capitation payment will be adjusted accordingly.

Members who withdraw their election of hospice services may request to enroll in the CHOICES program. We would expect that such occurrences are rare, since hospice is by definition "end of life" care. An approved PAE will be required to facilitate this enrollment.

Conflict of Interest, Disclosures of Ownership and Control, and Criminal Activity

Wellpoint includes language in all subcontracts and provider agreements and any and all agreements that result from an agreement between Wellpoint and TennCare to ensure that it is maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization. No part of the total agreement amount shall be paid directly, indirectly or through a parent organization, subsidiary or an affiliate organization to any state or federal

officer or employee of the state of Tennessee or any immediate family member (a spouse or minor children living in the household) 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 Wellpoint in connection with any work contemplated or performed under this Agreement unless disclosed to the Commissioner, Tennessee Department of Finance and Administration.

Quarterly, by January 30, April 30, July 30 and October 30 each year, or at other times or intervals as designated by the Deputy Commissioner of the Division of TennCare, disclosure shall be made by Wellpoint to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing, including a list of any state or federal officers or employees of the state of Tennessee, as well as any immediate family member of a state or federal officer or employee of the state of Tennessee who receives wages or compensation from Wellpoint, and a statement of the reason or purpose for the wages and compensation. The disclosures shall be made by Wellpoint and reviewed by TennCare in accordance with Standard Operating Procedures and the disclosures will be distributed to, among other persons, entities and organizations, the Commissioner, Tennessee Department of Finance and Administration, the Tennessee Ethics Commission, and the Fiscal Review Committee. Provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section. The provider shall report any disclosures under this section directly to the Deputy Commissioner of the Division of TennCare, Department of Finance and Administration in writing and in accordance with the quarterly intervals required under this section.

Wellpoint may be subject to sanctions, including liquidated damages, if it is determined that its agents or employees offered or gave gratuities of any kind to any state or federal officials or employees of the state of Tennessee or any immediate family member of a state or federal officer or employee of the state of Tennessee if the offering or giving of said gratuity is in contravention or violation of state or federal law.

In addition, Wellpoint is required by federal law to secure a current disclosure of ownership and a disclosure of criminal activity from each of its providers and contractors before executing any agreement with said provider or contractor. Such information shall be obtained from all individual physicians and provider entities that will be seeing patients, even if they are under a group agreement and shall be obtained at re-contracting and also at the following times: 1), at any time there is change to any such information on the disclosure form 2) at least once every three years 3) at any time upon request. Such information shall also be obtained from all of the staff at facilities who are considered managing employees or agents. This requirement also applies to nonparticipating providers when Wellpoint starts paying claims to them. TennCare will perform quarterly audits of randomly selected providers to determine that disclosures have been received. Failure to secure such disclosures may result in the assessment of penalties per occurrence/per day for every day of noncompliance. See Disclosure For Provider Entities, Disclosure For A Provider Person and Practitioner Attestation Forms in Appendix A.

Required Screenings for Excluded/Sanctioned/Debarred Employees/Contractors

The OIG of the United States Department of Health and Human Services (HHS-OIG) can exclude individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and all federal and state health care programs (as defined in section 1128B(f) of the Social Security Act [the Act]) based on the authority contained in various sections of the Act, including sections 1128, 1128A and 1156.

When the HHS-OIG has excluded a provider, federal and state health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities (section 1903(i)(2) of the Act and 42 CFR section 1001.1901(b)). This payment ban applies to any items or services reimbursable under a federal or state health care program, like Medicaid, which are furnished by an excluded individual or entity and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system.
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients when those payments are reported on a cost report or are otherwise payable by the Medicaid program.
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded (see 42 CFR section 1001.1901(b)). 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 listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed directly or indirectly by a Medicaid program

- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed directly or indirectly by a Medicaid program
- Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with and is paid by a Medicaid program
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed directly or indirectly by a Medicaid program

To further protect against payments for items and services furnished or ordered by excluded parties, Wellpoint requires all current providers and providers applying to participate in the Medicaid program to take the following steps to determine whether your employees and contractors are excluded individuals or entities:

1. Institute a policy requiring all employees and contractors immediately to disclose to you if and when they are or become excluded by the HHS-OIG or any other federal government agency.
2. Screen all employees, owners, managing agents and contractors against the System for Award Management (SAM) database (formerly GSA Excluded Parties List System) and HHS-OIG's List of Excluded Entities/Individuals database (a) prior to hiring or contracting, and (b) on a monthly basis to capture exclusions and reinstatements that have occurred since the last search.
3. Remove excluded employees and contractors immediately from responsibility for or involvement with business operations related to the federal and state health care programs and remove such employees and contractors from any position for which the employee's or contractor's compensation or the items or services furnished, ordered or prescribed by the employee or contractor are paid in whole or part, directly or indirectly, by federal or state health care programs or otherwise with federal or state funds at least until such time as the employee or contractor is reinstated into participation in the federal health care programs.
4. Report to Wellpoint any exclusion information discovered immediately via fax to the attention of the Wellpoint Tennessee Plan Compliance Officer at 866-796-4532.

Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by TennCare and Wellpoint dependent upon which entity identifies the payment of unallowable funds to exclude individuals. Additionally, all current providers are required to conduct background checks in accordance with state law and TennCare policy. At a minimum, background checks shall include a check of the Tennessee Abuse Registry, the Tennessee Felony Offender Registry, the National and Tennessee Sexual Offender Registry, the Social Security Master Death File, the Excluded Parties List System (EPLS) and the HHS-OIG List of Excluded Individuals/Entities (LEIE). All background checks required in this section must be completed prior to the start date of employment.

Subcontracting

A provider may not subcontract any TennCare-covered service without written authorization from Wellpoint. Failure by the provider to obtain written approval from Wellpoint for a subcontract that is for the purposes 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 Wellpoint and/or TennCare as overpayment.

Return of Overpayments

In accordance with the Affordable Care Act and TennCare policy and procedures, providers must report in writing overpayments to Wellpoint and TennCare Office of Program Integrity (OPI), and when it is applicable, return overpayments to Wellpoint within 60 days from the date the overpayment is identified. Any reported and/or returned overpayments must include a detailed reason why the funds are being returned. Overpayments not returned within 60 days from the date the overpayment was identified by the provider may be a violation of state or federal law.

Reporting of Abuse of Adults and Children

All current providers must report suspected abuse, neglect and exploitation of members who are adults to Wellpoint and Adult Protective Services in accordance with T.C.A. 71-6-101 et seq. The reports should provide the following information if known:

- The name and address of the adult or of any other person responsible for the adult's care
- The age of the adult
- The nature and extent of the abuse, neglect or exploitation, including any evidence of previous abuse, neglect or exploitation
- The identity of the perpetrator if known
- The identity of the complainant if possible
- Any other information that the person believes might be helpful in establishing the cause of abuse, neglect or exploitation

All current providers must report suspected brutality, abuse or neglect of members who are children to Wellpoint and Child Protective Services in accordance with T.C.A. 37-1-401 *et seq*. To the extent known by the reporter, the report should include:

- The name, address, telephone number and age of the child
- The name, address and telephone number of the person responsible for the care of the child
- The facts requiring the report

No Payment Outside of the U.S.

All covered services to be performed by providers shall be performed in the United States of America and the provider shall not provide any payments for covered items or services to any financial institution, entity or person located outside the United States.

Billing Agents and Alternative Payees

Providers are not permitted to assign TennCare funds/payment to billing agents or alternative payee without executing a billing agent or alternative payee assignment agreement. Such billing agents and alternative payees are subject to initial and monthly federal exclusion (LEIE) and debarment (SAM) screening if the alternative payee assignment is ongoing. Further, TennCare direct and indirect payments to out-of-country individuals and/or entities are prohibited.

Payment Error Rate Measurement and Provider Obligations

Payment Error Rate Measurement (PERM) is a program implemented by CMS to measure improper payments in the Medicaid Program and CHIP. CMS audits TennCare payments for these programs every three years. If you are one of the providers randomly selected to supply medical and payment records, you must comply with the CMS request within 60 days. For more information about PERM, check the TennCare website at www.tn.gov/tenncare/providers.html.

Provider-Preventable Conditions

Provider shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment by, at a minimum, nonpayment of provider preventable conditions, as well as appropriate reporting of these conditions to Wellpoint and TennCare.

Onsite Inspections and Audit of Records

TennCare, CMS, OIG, the Comptroller General or their representatives may conduct onsite inspections of premises, physical facilities and equipment of all health facilities and service delivery sites and audit any records or documents to be utilized by Wellpoint in fulfilling the obligations under the contract. Inspections may be made at any time during the contract period and without prior notice. The right to audit exists for 10 years from the final date of the contract period or the from the date of completion of any audit, whichever is later.

21. PROVIDER COMPLAINT PROCEDURES

Wellpoint has a formal process for the handling of complaints pertaining to administrative issues and nonpayment related matters. For payment disputes, see Section 16, Claims Payment Disputes. Providers may access this process by filing a written dispute.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint.

A provider can file a complaint in writing to:

Wellpoint
Attention: Operations Department – Provider Complaint
22 Century Boulevard, Suite 220
Nashville, TN 37214

Wellpoint will send an acknowledgement letter to the provider within 10 business days of receipt. At no time will Wellpoint cease coverage of care pending a complaint investigation.

22. TENNCARE COVERKIDS

Introduction

CoverKids is Tennessee's Children's Health Insurance Program (CHIP). Wellpoint administers the CoverKids program on behalf of the State of Tennessee. Effective January 1, 2021, CoverKids is supported by Wellpoint CoverKids Network. The CoverKids program provides both maternity and medical benefits for children under age 19 years and pregnant women 19 years and over. Pregnant women over the age of 19 stay eligible for CoverKids benefits through a 60-day postpartum period. This period begins the last day of the pregnancy and ends on the last day of the month in which the 60-day period ends. Those under age 19 receive 12 months of postpartum coverage under CoverKids.

Unlike TennCare Kids, CoverKids does have an out-of-pocket maximum which is calculated by the member's Managed Care Organization (MCO).

Benefits And Copays (Cost Sharing)

(Refer to the following link for additional information:
https://www.tn.gov/content/dam/tn/coverkids/documents/CoverKidsCopay.pdf)

	Benefit Level		
	1	2	3
Office/Outpatient Services			
Primary Care Visit • Office visit 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 Copay	$5 Copay	No Copay
Specialist Visit and Outpatient Surgery • Office visit with any specialty provider • Outpatient surgery including invasive diagnostic services (e.g., colonoscopy) - Single copay per date of service	$20 Copay	$5 Copay	No Copay
Behavioral Health (Mental Health, Alcohol and Drug Abuse)) Services • Office visit	$15 Copay	$5 Copay	No Copay

	Benefit Level		
	1	2	3
• Outpatient Mental health and substance use disorder - Single copay per date of service			
Chiropractors Only covered for children under age 19	$15 Copay	$5 Copay	No Copay
Rehabilitation and Therapy Services • Including Speech, Physical and Occupational • Limited to 52 visits per therapy type per Calendar Year	$15 Copay	$5 Copay	No Copay
Pharmacy - Benefits managed by OptumRx			
30 and 90-Day Supply/Specialty Pharmacy Drugs • The CoverKids formulary differs from TennCare's. The CoverKids formulary is available online at: optumrx.com/coverkids. • The CoverKids Pharmacy Benefit Appeal process differs from the CoverKids Medical Benefit Appeal process. For assistance in filing an appeal, the OptumRx Member Services Call Center is available 24/7 at: 844-568-2179.	$5 generic $20 preferred brand $40 non-preferred brand	$1 generic $3 preferred brand $5 non-preferred brand	No Copay
Non-Emergency Care			
Emergency Room Visit deemed as NOT a True Medical Emergency • Facility (Medical & Behavioral Health (Mental Health, Alcohol, and Substance use disorder), including Urgent Care • MUST be an In-Network Provider. If Out of Network provider, CoverKids will NOT pay.	$50 Copay	$10 Copay	No Copay

	Benefit Level		
	1	2	3
Inpatient Stays			
Inpatient Facility (Medical and Behavioral Health [Mental Health, Alcohol, and Substance use disorder]) • Copay 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 Copay per admission	$5 Copay per admission	No Copay
Vision Services- These Services are only eligible for children under age 19. When both frames and lenses are ordered at the same time, one copay is charged			
Prescription Eyeglass Lenses • Including bifocal or trifocal • Limited to one per Plan Year	$15 Copay $85 Max Benefit	$5 Copay $85 Max Benefit	No Copay
Prescription Contact Lenses instead of Eyeglass Lenses Limited to one per Plan Year	$15 Copay $150 Max Benefit	$5 Copay $150 Max Benefit	No Copay
Frames Limited to every 2 Plan Years	$15 Copay $100 Max Benefit	$5 Copay $100 Max Benefit	No Copay

CoverKids Benefits (Effective January 1, 2021)

SERVICE	BENEFIT LIMIT
Ambulance Services, Air and Ground (Emergency)	As medically necessary. Non-emergency transportation is not covered.
Chiropractic care	Children Under Age 19: Maintenance visits not covered when no additional progress is apparent or expected to occur. Mothers (Age 19 and over) of Eligible Unborn Children: Not Covered
Clinic Services and other Ambulatory Health Care Services	As medically necessary

SERVICE	BENEFIT LIMIT
Dental Services	Dental services shall be provided by the Dental Benefits Manager (DBM) DentaQuest. Adult dental benefits are not applicable to members who have CoverKids. CoverKids children have dental benefits through age 18. The following benefits are covered by the CoverKids program for children under age 19 as medically necessary, subject to the limitations stated below: Prevention: • Oral exams - 2 per calendar year • Teeth Cleanings - 2 per calendar year • X-rays - Bitewings 2 years of age and older, 1 set per calendar year • Full mouth x-rays 1 set every three calendar years • Fluoride (Ages 1 -18 years - 2 per calendar year) • Sealants - For permanent molars, 1 per lifetime per tooth • Silver Diamine Fluoride (SDF) four applications, per tooth per lifetime Treatments • Fillings • Crowns • Extractions (teeth removal) • Anesthesia - Provided only when medically necessary Dental services: Limited to a $1,000 annual benefit maximum per enrollee. Orthodontic services: Limited to a $1,250 lifetime benefit maximum per enrollee. Covered only after a 12-month waiting period. Facility, medical and anesthesia services related to the dental service that are not provided by a dentist or in a dentist's office shall be covered services provided by the CONTRACTOR (Wellpoint) when the dental service is covered by the DBM.

SERVICE	BENEFIT LIMIT
	Mothers (Age 19 and over) of Eligible Unborn Children: Not Covered. NOTE: The summary of benefits above is only intended for general informational purposes and may not reflect all updates or modifications to the plan benefits. For more information on Dental Benefits please contact the DBM (DentaQuest) at 855-418-1622 or Dentaquest.com.
Disposable Medical Supplies	As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare Division rules and regulations.
Durable Medical Equipment (DME)	Must be medically necessary. Durable medical equipment and other medically related or remedial devices: • Limited to the most basic equipment that will provide the needed care. • Hearing aids are limited to one per ear per calendar year up to age 5, and limited to one per ear every two years thereafter. DME services shall be covered in accordance with TennCare Division Rules & Regulations and Wellpoint Clinical Guidelines and Policies.
Home Health Services	Limited to 125 visits per enrollee per calendar year.
Hospice Care	As medically necessary. Shall be provided by a Medicare-certified hospice.
Inpatient Hospital Services	As medically necessary, including rehabilitation hospital/ facility.
Inpatient Mental Health and Substance Use Disorder Services	As medically necessary.
Lab and X-ray Services	As medically necessary.

SERVICE	BENEFIT LIMIT
Outpatient Mental Health and Substance Use Disorder Services	As medically necessary.
Outpatient Hospital Services	As medically necessary.
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.	Limited to 52 visits per calendar year per type of therapy.
Physician Inpatient Services	As medically necessary.
Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services	As medically necessary.
Prenatal care and pre-pregnancy family services and supplies	As medically necessary.
Preventive Care Services	As medically necessary.
Skilled Nursing Facility services	Limited to 100 days per calendar year following an approved hospitalization.
Surgical Services	As medically necessary.
Vision Services	Children Under Age 19: 1. Annual vision exam including refractive exam and glaucoma screening. 2. Prescription eyeglass lenses. Limited to one pair per calendar year. $85 maximum benefit per pair. 3. Eyeglass frames. Coverage for replacement frames limited to once every two calendar years. $100 maximum benefit per pair.

SERVICE	BENEFIT LIMIT
	4. Prescription contact lenses in lieu of eyeglasses. Limited to one pair per calendar year. $150 maximum benefit per pair. Mothers (Age 19 and over) of Eligible Unborn Children: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), shall be covered as medically necessary. Routine periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing fitting or changing eyeglass and/or contact lenses are not covered. One pair of cataract glasses or lenses is covered for adults following cataract surgery.

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
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.

An individual or facility, other than a practitioner, duly licensed to provide covered services and listed in the Directory 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:

1. There are benefits for Out-of-Network, hospital-based Practitioners in a Network facility.
2. In a true Emergency, there are benefits for Out-of-Network Providers (Facility and Practitioners).

Exclusions from Coverage for CoverKids participants

1. The services and items set out in the TennCare Medicaid Exclusions Rule 1200-13-13-.10(1) and (3)(b) are excluded from coverage by the CoverKids program. View TennCare's benefit

exclusions in the Exclusions section of the TennCare Rules on https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm Find 1200-13-13-10.

2. In addition to the services and items excluded by (1), view other services, products and supplies also excluded from coverage by the CoverKids program. View TennCare's benefit exclusions for CoverKids in the Exclusions section of the TennCare Rules on https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm Find 1200-13-21.

CoverKids participants are not eligible for enrollment in the Vaccines for Children (VFC) program. The providers may bill for vaccines and the administration fee's and will be reimbursed as per their contractual fee schedule.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) does not apply to CoverKids. We do not require prior authorization for periodic and interperiodic screens PCP's conduct.

APPENDIX A — FORMS

Certification and Claim Submission Forms

1. *WIC Referral Form* — A sample form that providers may use to make referrals to WIC, a provider agency
2. *Precertification Request* — Providers can use this form to submit a request for a precertification or for a notification of services
3. *CMS 1500 Claim Form* — A sample claim form
4. *CMS 1450 Claim Form* — A sample claim form

WIC Referral Form

This is a referral to a Women, Infant and Children (WIC) provider agency. Medicaid recipients eligible for WIC benefits include the classifications listed below. Please check the category that most appropriately describes the individual that is being referred for services.

- ☐ Pregnant woman
- ☐ Woman who is breast-feeding her infant(s) up to one year postpartum
- ☐ Woman who is not breast feeding her infant(s) up to six months postpartum
- ☐ Infant under age one
- ☐ Child under age five

Name of individual being referred: _____

Address: _____

_____

Telephone Number: _____

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian.

Physician's Name: _____

Telephone Number: _____

Date of Referral: _____

Send completed form to:

Local WIC Program Center: _____

Address: _____

_____

Telephone Number: _____

Precertification Request Form

Today's date:
Provider return fax:

Prior authorization phone: 833-731-2154
Prior authorization fax: 800-964-3627

Member information		
First name:	Last name:	Wellpoint member ID:
Address:		City, State and ZIP code:
DOB:	Contact phone:	
Additional member information:		

Referring provider ☐ Participating ☐ Nonparticipating			
Full name:			
NPI:		Provider ID:	Tax ID number (TIN):
Office contact name:		Office phone:	Office fax:
Address:	City, State and ZIP code:		
Specialty:			

Servicing provider ☐ Participating ☐ Nonparticipating			
Full name:			
NPI:		Provider ID:	TIN:
Office contact name:		Office phone:	Office fax:
Address:	City, State and ZIP code:		
Specialty:			

Servicing facility ☐ Participating ☐ Nonparticipating			
Name:			
NPI:		Provider ID:	TIN:
Facility contact name:		Facility phone:	Facility fax:
Address:		City, State and ZIP code:	

Requested service (for type of service, check all that apply)	Date/date range of service:
ICD-10 code(s):	
CPT® code(s) (include requested units):	

Type of service: ☐ Outpatient ☐ Planned inpatient ☐ Emergent inpatient ☐ Skilled nursing facility ☐ Long-term services and supports/long-term care ☐ Home health

☐ Durable medical equipment ☐ Diagnostic study ☐ Hospice ☐ Office visit ☐ Personal care services ☐ Other:

Place of service: ☐ Hospital ☐ Ambulatory surgery center ☐ Office ☐ Home ☐ Independent lab ☐ Nursing facility
☐ Other:

Additional information:

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Wellpoint, please provide the authorization number with your submission.

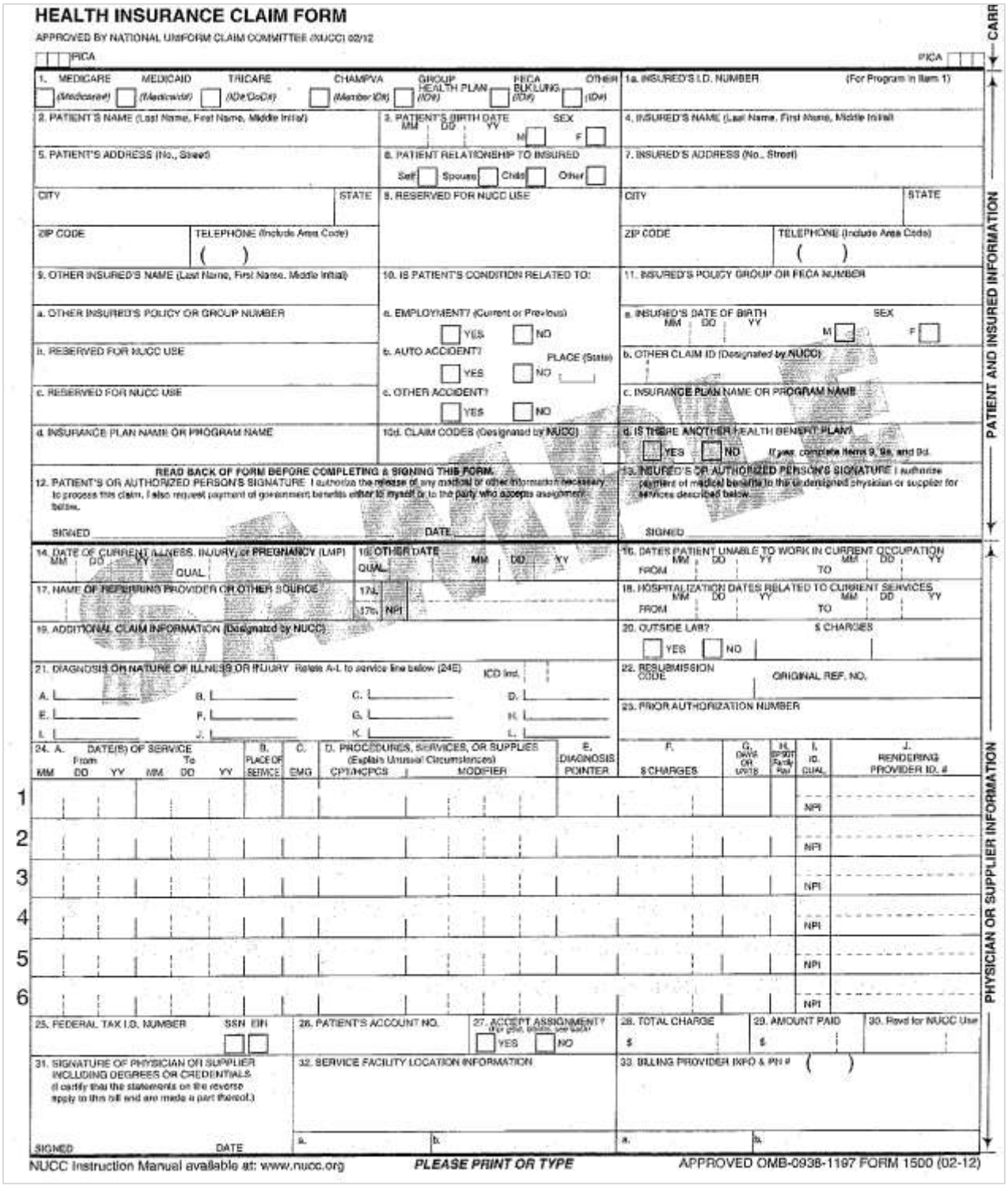
To prevent any delay in processing your request, please fill out this form in its entirety.

Emergent: Use for all nonelective inpatient admissions only when provider indicates that the admission was urgent, emergent, or expedited (for admission on same day).

Urgent: Use for outpatient services only when provider indicates that the service is urgent, emergent, or expedited.

CMS-1500 (02-12) Claim Form

This form (and the form change log and instruction manual) is also available from the Centers for Medicare and Medicaid Services at cms.hhs.gov.



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? PLACE (State) YES NO

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. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

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

CARR

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTI0NS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TENNCARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFA 411.24(a). If Item 9 Is completed, the patient's signature authorizes release of the Information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a,4,6,7,9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the Information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor;3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision;4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including bin not limited to the Federal anti-kickback statute and Physician Sell-Referral law (commonly known as Stark law);5} the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE;6} for each service rendered incident to my professional service, the identity (legal name and NPI, license number, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1} they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an Integral, although Incidental part of a covered physician service, 3) they must be of kinds commonly furnished In physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TENNCARE claims, I further certify that I(or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to line and Imprisonment under applicable Federal laws.

NOTICE TO PAT1ENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMAT10N
(PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for intonation needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a}, 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a} and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086;5 USC 8101 et seq; and 30 USC 901 et seq;38 USC 613;E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. E.g., it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No.09-70-0501, titled, •carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No.177, page 37549, Wed. Sept. 12,1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol.55 No.40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S)·Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICI\RE.

DISCLOSURES: Voluntary; however, failure to provide intonation will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply intonation. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party Is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties lor withholding this intonation.

You should be aware that P.L. 10Q-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify Information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to Individuals under the State's Title XIX plan and to furnish Information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

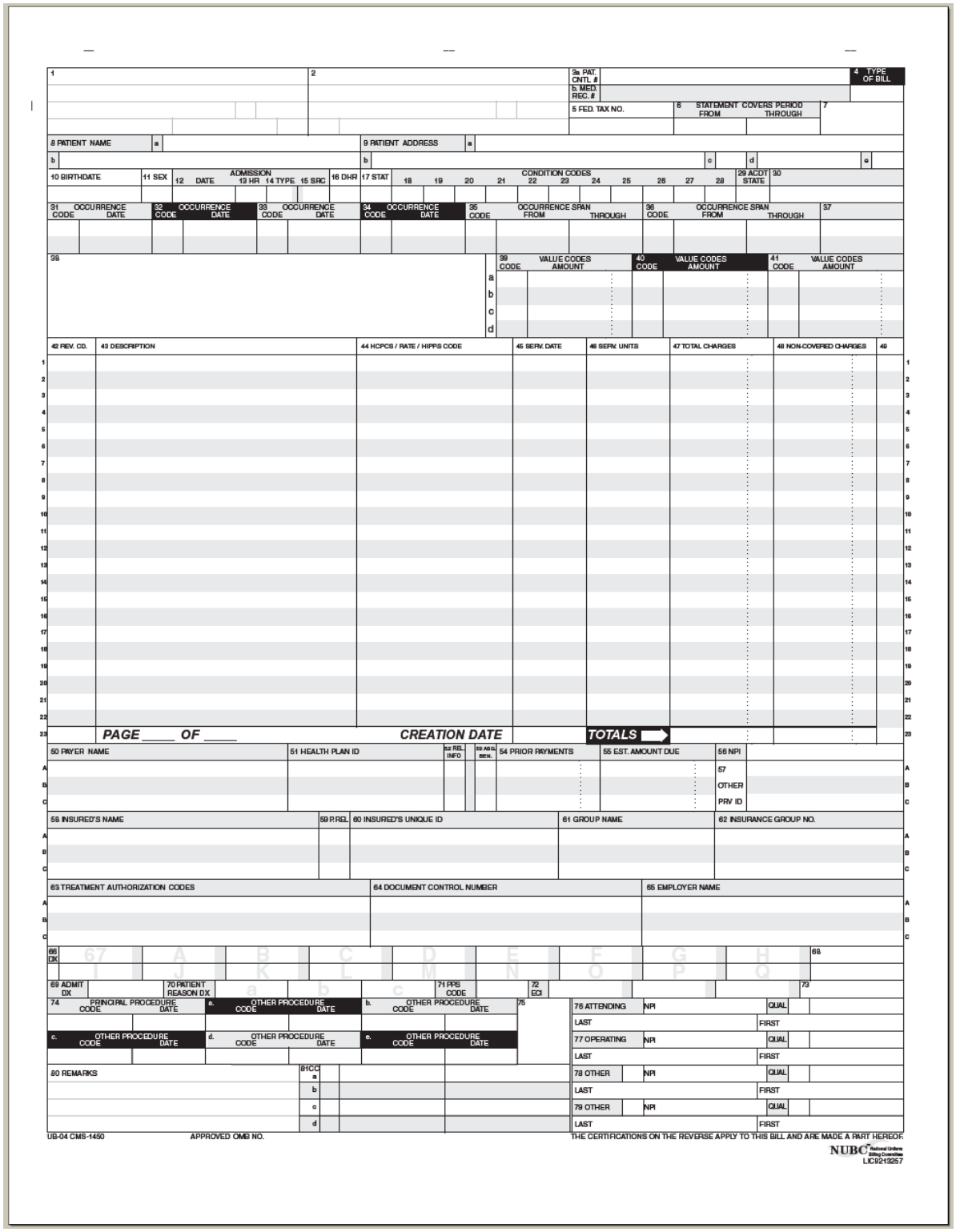
SIGNATURE OF PHYSICIAN (OR SUPPIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PAA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

UB-04 CMS-1450 Claim Form

This form is also available from the Centers for Medicare and Medicaid Services at cms.hhs.gov.



UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Overpayment Refund Notification Form

In order for the overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is a Wellpoint check, please include a completed form specifying the reason for the return of the check.

Provider information	
Provider name/contact:	
Contact number:	Provider ID:
NPI number:	Provider tax ID:
Subscriber ID:	DCN number (Displayed on CCU letter):
Member information	
Member name:	
Member account number:	Date of service:
Total billed charges:	Claim number:
Overpayment information	
Total check amount:	Date overpayment identified:
Date range/time frame the issue(s) occurred:	Specific CPT/HCPCS/DRG code(s) involved with the reimbursement:
Have you performed due diligence to ensure this voluntary refund is isolated only to the identified claim(s)? ☐ Yes ☐ No	
Did you self-identify the overpayment? ☐ Yes ☐ No	
If no, then briefly explain who identified the overpayment and issues or billing codes that were identified.	

Additional claims(s)			
Claim number	Member name	Member account#	Date of

Reason for refund or check return: ☐ Wellpoint letter ☐ Contract rate change ☐ Duplicate payment ☐ Incorrect member ☐ Incorrect provider		☐ Negative balance ☐ Other health insurance/third-party liability ☐ Payment error ☐ Billed in error/adjusted charge ☐ Other: _____	

All refund checks should be mailed with a copy of this form to:
Wellpoint
P.O. Box 933657
Atlanta, GA 31193-3657

Once the Wellpoint Cost Containment Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this *Overpayment Refund Notification Form*.

Medical Record Forms

These are sample medical record forms that the provider may choose to use.

Clinical Information Form

_____

Patient Name

PATIENT DIAGNOSES	DATE DIAGNOSED

HEALTH SCREENS	DATE PERFORMED				
RECTAL EXAM					
PSA					
CHEST X-RAY					
SIGMOIDOSCOPY					
EKG					

SURGICAL HISTORY	HABITS
	PHARMACY/TELEPHONE

Problem List 1

Problem Number	Date	Active Problem/Diagnosis	Date Resolved

Addressograph

MEMBER NAME: _____

DOB _____ EFF DATE _____

ID #_____ SSN #_____

Problem List 2

NAME: _____
DOB: _____
TELEPHONE: _____
MEMBER ID NUMBER:_____

PROBLEM LIST

Code	Active	Inactive
	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.
	7.	7.
	8.	8.
	9.	9.

MEDICATION

	Start	Stop		Start	Stop
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		

ALLERGIES

Patient Drug Profile

Addressograph

Change in dosage requires new medication entry.

			REFILL			REFILL			REFILL		
Start date	MD's initials	Medication/dosage frequency	Date	# Refill	MD nurse	Date	# Refill	MD nurse	Date	# Refill	MD nurse

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

HIV Antibody Blood Forms

Counsel for HIV Antibody Blood Test: This is a sample counsel form that the provider may choose to use.
Consent for HIV Antibody Blood Test: This is a sample consent form that the provider may choose to use.
Results of the HIV Antibody Blood Test: This is a sample results form that the provider may choose to use.

Counsel for HIV Antibody Blood Test

use patient imprint

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled
(Name of physician or other provider)
and provided me with:

A. Information concerning how HIV is transmitted
B. The benefits of voluntary testing
C. The benefits of knowing if I have HIV or not
D. The treatments which are available to me and my unborn child should I test positive
E. The fact that I have a right to refuse the test and I will not be denied treatment

I have consented to be tested for infection with HIV. ☐

I have decided not to be tested for infection with HIV. ☐

This record will be retained as a permanent part of the patient's medical record.

_____ _____
Signature of Patient Date

_____
Signature of Witness

Consent for the HIV Antibody Blood Test

I have been told that my blood will be tested for antibodies to the virus named HIV (Human Immunodeficiency Virus). This is the virus that causes AIDS (Acquired Immunodeficiency Syndrome), but it is not a test for AIDS. I understand that the test is done on blood.

I have been advised that the test is not 100 percent accurate. The test may show that a person has antibodies to the virus when they really don't — this is a false positive test. The test may also fail to show that a person has antibodies to the virus when they really do — this is a false negative test. I have also been advised that this is not a test for AIDS and that a positive test does not mean that I have AIDS. Other tests and examinations are needed to diagnose AIDS.

I have been advised that if I have any questions about the HIV antibody test, its benefits or its risks, I may ask those questions before I decide to agree to the blood test.

I understand that the results of this blood test will only be given to those health care workers directly responsible for my care and treatment. I also understand that my results can only be given to other agencies or persons if I sign a release form.

By signing below, I agree that I have read this form or someone has read this form to me. I have had all my questions answered and have been given all the information I want about the blood test and the use of the results of my blood test. I agree to give a tube of blood for the HIV antibody tests. There is almost no risk in giving blood. I may have some pain or a bruise around the place that the blood was taken.

_____ _____

Date Patient's/Guardian Signature

_____ _____

Witness Signature Patient's/Guardian's Printed Name

_____

Physician Signature

Wellpoint recognizes the need for strict confidentiality guidelines.

Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization for use or disclosure of the results of a blood test to detect antibodies to HIV, the probable causative agent of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you to comply with the terms of Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _____ to furnish
(Name of physician, hospital or health care provider)
to _____ the results of the blood test for
(Name or title of person who is to receive results)
antibodies to HIV.

C. USES

The requester may use the information for any purpose, subject only to the following limitation: _____.

D. DURATION

This authorization shall become effective immediately and shall remain in effect for 12 months indefinitely or until _____, 20___, whichever is shorter unless I withdraw my permission.

I have the right to withdraw my permission at any time. I cannot take back information that has been used to take action on my case or that has been given to you before I take back my permission. To withdraw my permission, I can write the Department of Human Services in my county, or write my doctors, hospitals or other health care providers or insurance company or health plan.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: ☐ Yes ☐ No _____ Initial

Date: _____, 20_____ _____
Signature

_____
Printed Name

G. If this authorization is signed by my personal representative, a description of such representative's authority to act for me in the capacity of health care decisions must be provided. Legal authority as personal representative, i.e., conservatorship, etc., must be attached or documentation must be on file in plan or provider's records.

Note: this form must be in at least 8-point type.

Blood Lead Risk Forms

Verbal Blood Lead Risk Assessment: This is a sample assessment form that the provider may choose to use.

Blood Lead Testing for High-risk Children: This is a sample assessment form that the provider may choose to use.

Elevated Blood Lead Testing Result Form: This is a sample results form the provider may choose to use.

Verbal Blood Lead Risk Assessment

Member Name: _____
Date: _____
ID Number: _____
Person Interviewed/Relationship: _____

	Yes	No
Does your child live in or regularly visit a house built before 1960? Does the house have chipping or peeling paint?		
Was your child's day care center/preschool/babysitter's home built before 1960? Does the house have chipping or peeling paint?		
Does your child live in or regularly visit a house built before 1960 with recent, ongoing or planned renovation or remodeling?		
Have any of your children or their playmates had lead poisoning?		
Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding or pottery.		
Do you give your child home or folk remedies that may contain lead?		

Blood Lead Testing for High-Risk Children

Member Name:
_____

Date:
_____

ID Number:
_____

Person Interviewed/Relationship:
_____

Has your child's blood been tested for lead?	Yes	No
When your child was last tested?	Date:	
What was the result?	Result:	
Has the child seen the pediatrician since his or her last blood test?	Yes	No
When?	Date:	
Was the child tested for lead poisoning?	Yes	No
When?	Date:	

- If the PCP has not seen the child, encourage and help arrange a visit.
- If it has been over one year since the child's last visit, encourage and help arrange a visit.
- If the child has been/is being treated for lead poisoning, apply risk assessment and encourage continuation of follow-up. Assist member through any barriers identified.

Elevated Blood Lead Testing Result Form

Member Name:_____ Date: _____

ID Number: _____ Date of Birth: _____

Provider Name: _____ Provider ID Number: _____

Has a risk assessment been performed? ❑Yes ❑No

Environmental risks (please specify):

_____

_____

_____

When was the member tested for lead poisoning? Date:_____

Result:_____

Laboratory that performed testing: _____

Planned follow-up treatment:

_____

_____

_____

_____ _____

Provider Signature Date

Please fax the completed form to Attn: Pediatric CM at 866-495-5788 within five days of notification of an elevated lead blood level.

Abortion, Hysterectomy, and Sterilization Forms

Every time you submit a claim for the procedures for abortion, hysterectomy, and sterilization services and related procedures (i.e., ancillary procedures such as anesthesia services), you must include one of the following applicable forms for reimbursement and/or such form must be on file for the service. The form must be filled out correctly and in its entirety:

- *Certification of Medical Necessity for Abortion*
- *Sterilization Consent Form*
- *Hysterectomy Acknowledgment Form*

Printable forms and instructions to complete the forms are on the Division of TennCare website at https://www.tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html. Failure to fully complete these forms in accordance with the applicable instructions will result in the denial of your claim.

Note: Wellpoint and TennCare will only accept the Sterilization Consent form with the 2018 expiration date. Claims with consent forms that show any other expiration date will be denied.

Practitioner Evaluation and Audit Tools

Practitioner Evaluation and Audit Tools: These tools may be used by Wellpoint when auditing provider medical records for credentialing or investigation of quality management issues.

Practitioner Office Site Evaluation

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Manager: _____ Last _____ First

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____ Last _____ First

	Point Value	Y	N	N/A	Point Score
A. Physical Accessibility:	10				
1 Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathroom(s)?	2				
2 Is accessible parking clearly marked? (Sign/painted symbol on pavement) Only applies to off-street parking; N/A is parking is street-side only.	2				
3 Are doorways and stairways that provide access free from obstructions at all times and allow easy access by wheelchair or stretcher?	2				
4 Are exits clearly marked and is there emergency lighting in instances of power failure?	2				
5 Are building and office suite clearly identifiable (clearly marked office sign)?	2				
B. Physical Appearance:	10				
1 Is the office clean and well kept? (Neat appearance, no trash on floor, furniture in good repair, no significant spills on floors / furnishings)	2				
2 Is treatment area clean and well kept? (No significant spills on floors, counters or furnishings, no trash on floor)	2				
3 Does office have smoke detector(s)?	2				
4 Easy access to a clean, supplied bathroom? (Soap, toilet paper, hand towels and hand washing instructions)	2				
5 Fire extinguishers clearly present and fully charged and recently inspected (even if office has sprinkler system)?	2				
C. Adequacy of Waiting and Examining Room Space:	8				
1 Is there adequate seating in the waiting area (based on number of physicians/practitioners)? *	1				
2 Does the staff provide extra seating when the waiting room is full?	1				
3 Is there a minimum of 2 exam rooms per scheduled provider? (2 consultation rooms for Behavioral Health (BH) Providers)	1				
4 Is there privacy of exam/consultation rooms? (Doors or curtain closures; rooms cannot be visualized from waiting room)	1				
5 Are exam/consultation rooms reasonably sound proof? (Conversations cannot be heard from waiting room or other exam rooms)	1				
6 An otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible? N/A for BH Providers	1				
7 For OB/GYNs only or any physician/practitioner providing OB Care: Does the office have the following readily accessible: (If not OB/GYN, check N/A)					
7a - A fetalscope (DeLee and/or Dopler) and a measuring tape for fundal height measurement?	1				
7b - Supplies for dipstick urine analysis (glucose, protein)?	1				
D. Adequacy of Medical Records:	20				
1 Are there individual patient records?	2				
2 Are records stored in a manner which ensures confidentiality - are they kept in an area not accessible by patients?	2				
3 Are all items secured in the chart?	2				
4 Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	2				
5 Medical Recordkeeping practices:					
5a Is there a place to document allergies?	2				
5b Is there a place to document current medication list?	2				
5c Is there a place to document current chronic problems list?	2				
5d Is there an immunization record on pediatric charts? N/A for BH Providers	2				
5e Is there a growth chart on pediatric charts? N/A for BH Providers	2				
5f Is there a place to document presence/absence and discussion of a patient self-determination / advance directive? (If not appropriate, check N/A)	2				

* 1 Provider = 6 seats, 2 Providers = 8 seats, 3 Providers = 11 seats, 4 Providers = 14 seats, 5 Providers = 17 seats

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Manager: _____ Last _____ First

Physician/Practitioner Name(s):

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

_____ Last _____ First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____ Last _____ First

	Point Value	Y	N	N/A	Point Score
E. Appointment Availability: Is the physician/practitioner available:	15				
1 Routinely within a wait time of 45 minutes or less? (Ask office manager)	1				
2 At least 4 days or 20 hours per week? **NY:** At least 16 hours per week at this office location or has waiver been granted?	1				
3 **IL Only-All other Plans N/A:** Maximum number of intermediate/limited encounters is 6 per hour?	1				
4 **IL Only-All other Plans N/A:** Serious care (not a medical emergency) within the same day of the date of the request?	1				
5 **GA Only-All other Plans N/A:** PCP adult sick visits w/n 72 hrs. and/or PCP pediatric sick visits w/n 24 hrs.?	1				
6 **GA Only-All other Plans N/A:** Specialist visits w/n 30 calendar days of request?	1				
7 **GA Only-All other Plans N/A:** Mental Health Providers w/n 14 calendar days of request?	1				
8 **GA Only-All other Plans N/A:** Initial visit for pregnant women w/n 14days of request?	1				
9 24 hour call coverage for emergencies? (By themselves or by covering provider) Crisis Hotline **Yes/No (BH Providers only)**	1				
10 Urgent care within 24 hours?	1				
11 Routine/problem care within 2 weeks **FL, NM, NY, OH, SC, TN,TX;** 10 days-**VA, MD/DC** ; 3 weeks-**GA, IL;** 28 days-**NJ,** of appt. request	1				
[All except GA - including first visit after pregnancy determination (excludes home pregnancy test)]? **Please circle appropriate Health Plan**					
12 Are phone lines adequate to handle volume of total patient population?	1				
13 Physical/wellness exams for adults within 30 days-**VA, MD/DC, FL, SC, NM, NY, OH, TN;** 10 weeks **TX;** 5 weeks-**IL;** baseline	1				
physical for new members w/n 180 days of enrollment-**NJ? Please circle appropriate Health Plan - N/A for BH Providers**					
14 Physical/wellness exams for children within 30 days-**VA, MD/DC, FL, SC, GA, NM, NY, OH, TN;** 2 months.-**TX and NJ;** from the	1				
date of contact/request? **Please circle appropriate Health Plan - N/A for BH Providers**					
15 **NJ Only:** Baseline physicals for new child members/adult members of DDD w/n 90 days of enrollment or according to EPSDT	1				
guidelines? **- N/A for BH Providers and for all Plans except NJ**					
F. Documentation Evaluation: Does the office have the following:	17				
1 No-show follow-up procedure/policy? (If not written, can the staff verbally explain the process?)	2				
2 A chaperone policy? (If provider does not have written chaperone policy, office must provide statement on letterhead indicating chaperone	2				
will be in exam room.) **THIS ELEMENT IS A MUST HAVE TO PASS SITE VISIT & PARTICIPATE**					
3 Is the Patient Bill of Rights posted?	1				
4 Is Medical License/Occupational License displayed?	1				
5 **TX and FL only:** Is there a posted notice of member complaint process?	1				
6 **FL Only:** Is the HMO hotline number posted?	1				
6 **FL Only:** If Provider does not carry malpractice insurance, is required patient notification statement posted in prominent place in	1				
reception area?					
7 Is there a written policy for hand washing, gloved procedures, and disposal of sharps, etc.? May not be applicable for BH Providers	2				
in private practice setting.					
8 Is there a written OSHA Exposure Control Plan which includes Universal Precautions & Blood Born Pathogen exposure	2				
procedures for staff? May not be applicable for BH Providers					
9 **FL & TX Only:** Posted copy of CLIA Certificate or Certificate of Waiver, if applicable? **(Attach a copy to site evaluation tool)**	1				
TX Only: PCPs providing TX HealthSteps services MUST have CLIA, CLIA Waiver or lab services on site within same bldg.					
10 **FL & TX Only:** Posted copy of current radiology services certification or licensure, if applicable? **(Attach a copy to site evaluation tool)**	1				
11 If Provider employs NPs, PAs or other mid-level providers that will asseses health care needs of members, do they have written policies that	2				
describe duties and supervision of such providers?					
G. HIPAA Requirements/Regulations	8				
1 Is there a written P & P addressing permitted uses/disclosures and required disclosures of patient PHI/IIHI?	2				
2 Does Provider have authorization forms available to designate Personal Representative(s) to which PHI/IIHI may be	2				
released and/or disclosed?					
3 Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	2				
4 Is there a designated Compliance & Privacy person? **Name:**_____	2				

PRACTITIONER OFFICE SITE EVALUATION - ALL PLANS

INFORMATION BELOW MUST BE DOCUMENTED AT TOP OF EACH PAGE OF SITE VISIT FORM! ALL QUESTIONS MUST BE ANSWERED.

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Manager: _____
Last First

Physician/Practitioner Name(s):

_____ _____
Last First

_____ _____
Last First

_____ _____
Last First

Office Address _____

Specialty(ies) _____ **Date** _____ **Reviewer Name** _____
Last First

		Point Value	Y	N	N/A	Point Score
H.	**Office Evaluation**	12				
1	Is there an approved process for bio-hazardous disposal?	2				
2	Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	2				
3	Is there a plan/procedures for narcotic inventory, control and disposal?	2				
4	Are vaccines and other biologicals refrigerated, as appropriate?	2				
5	Observe 2-3 office staff interactions: Are they professional and helpful?	2				
6	Is emergency equipment available (an oral airway and ambu bag)? If not, note how staff accommodates emergency situations.	2				

To complete the form, answer every question, then total the number of points and record here. **100** **TOTAL** ☐

A copy of this complete profile was received by:

_____ Office Manager / Physician/Practitioner **(please circle one)**
Office Manager/Physician/Practitioner Signature

REMINDER - DO NOT DEDUCT POINTS FOR THOSE QUESTIONS THAT ARE ANSWERED N/A
INCLUDE THOSE POINTS FOR N/A ANSWERS IN TOTAL SCORE

REMINDER - IF PROVIDER HAS A CLIA CERTIFICATE/CERTIFICATE OF WAIVER AND/OR RADIOLOGY LICENSURE
YOU MUST ATTACH A COPY OF THE DOCUMENTS TO THIS SITE VISIT FORM

Advance Directive

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS:
By checking the appropriate line below, I specifically:
_____ Authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water or other nourishment or fluids.

ORGAN DONOR CERTIFICATION:
Notwithstanding my previous declaration relative to the withholding or withdrawal of life-prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated, § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues.
By checking the appropriate line below, I specifically:
_____ Desire to donate my organs and/or tissues for transplantation
_____ Desire to donate my _____
(Insert specific organs and/or tissues for transplantation)

_____ DO NOT desire to donate my organs or tissues for transplantation

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal.

The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, § 32-11-103.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

In acknowledgment whereof, I do hereinafter affix my signature on this the _____ day of _____, 20___.

_____
Declarant

We, the subscribing witnesses hereto, are personally acquainted with and subscribe our names hereto at the request of the declarant, an adult, whom we believe to be of sound mind, fully aware of the action taken herein and its possible consequence.

We, the undersigned witnesses, further declare that we are not related to the declarant by blood or marriage; that we are not entitled to any portion of the estate of the declarant upon the declarant's decease under any will or codicil thereto presently existing or by operation of law then existing; that we are not the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient; and that we are not persons who, at the present time, have a claim against any portion of the estate of the declarant upon the declarant's death.

_____
Witness

_____
Witness

STATE OF TENNESSEE
COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20___.

_____
Notary Public

My Commission Expires: _____

Advanced Care Plan

TennCare's Advance Directive forms are available at tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html.

Appointment of Health Care Agent

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City State ZIP Code	City State ZIP Code
_(__)_____	_(__)_____
Area Code Home Phone Number	Area Code Home Phone Number
_(__)_____	_(__)_____
Area Code Work Phone Number	Area Code Work Phone Number
_(__)_____	_(__)_____
Area Code Mobile Phone Number	Area Code Mobile Phone Number

_____ _____

Patient's name (please print or type) Date Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, either block A or block B must be properly completed and signed.

Block A Witnesses (two witnesses required)

1. I am a competent adult who is not named above.

_____

I witnessed the patient's signature on this form. Signature of witness number 1

2. I am a competent adult who is not named above. I am not related

_____

to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. Signature of witness number 2

Block B Notarization
STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 3, 2005.

Behavioral Health Forms

Behavioral Health Forms: Our Wellpoint TN Provider website includes an array of Behavioral Health Forms including request forms, discharge forms, as well as programmatic specific documents. Please visit the Behavioral Health section of our website at the following link:

Behavioral health | Wellpoint Tennessee, Inc.

For Wellpoint use only. Authorization number:

Member Nam_____ Member DOB: _____

PF-TN-0013-12

Authorization to Release Information

Instructions: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand that this Authorization is Voluntary, and that if the Person or Organization Authorized to Receive the Information is Not a Health Plan or Health Care Provider, the Released Information May No Longer Be Protected by Federal Privacy Regulations (HIPAA).

I,_____/_____, authorize
(Print name of service recipient) (Print date of birth)
_____ /_____
(Print name of agency/program making disclosure) and (Mailing address of agency/program making disclosure)

To disclose to_____ /_____
(Print name of person(s) or organization to which disclosure is to be made, and their mailing address)

The following information: _____
(Describe the specific information to be used or disclosed)
_____
_____

The purpose of the authorized disclosure is to:
_____
(Specific purpose/use of the disclosure)
_____
I understand that I Am Not Required to Sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is Not Conditioned on my Execution of this Authorization. I may Revoke this Consent in Writing at Any Time, Except to the extent that Action has been Taken in Reliance on it, and that, in any event, this Consent Expires Automatically as follows:
_____
(Specify the date, event, or condition of expiration)
X_____ _____

(Signature of service recipient who is 16 years of age or older) (Date)

(All blanks must be filled in before signing)

*Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient; and (6) the treatment review committee, acting within the authority and scope of §33-6-107, Tennessee Code Annotated. *The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.*

X_____ _____

*(Signature of individual acting on behalf of the service recipient) (Date)

(All blanks must be filled in before signing)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

**If a service recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:

X_____ /_____ X_____/_____

**(Witness) (Date) **(Witness) (Date)

MHDD-5025 Revised 03-06

Behavioral Health Initial Review Form for Inpatient and Partial Hospital Programs

Please submit your request electronically using our preferred method at https://availity.com.* If you prefer to fax this form instead, you may send it to 844-452-8071.

Today's date:		
Contact information		
Level of care: ☐ Inpatient psychiatric ☐ Psychiatric RTC ☐ IOP mental health ☐ Inpatient detox	☐ PHP mental health ☐ PHP substance use ☐ Inpatient substance use rehab ☐ IOP substance abuse	☐ Substance use RTC ASAM level, if appropriate:
Member name:		
Member ID or reference #:	Member DOB:	
Member address:		
Member phone:	Facility account #:	
For child/adolescent, name of parent/guardian:		
Primary spoken language:		
Name of utilization review (UR) contact:		
UR contact phone:	UR contact fax:	
Admit date:		
☐ Voluntary ☐ Involuntary (If involuntary, date of commitment:)		
Admitting facility name:		
Facility provider # or NPI:		
Attending physician (first and last name):		
Attending physician phone:	Provider # or NPI:	
Facility unit:	Facility phone:	
Discharge planner name:		
Discharge planner phone:		
Diagnosis (psychiatric, chemical dependency, and medical)		
Precipitant to admission (Be specific. Why is the treatment needed now?)		
Risk of harm to self		
If present, describe:		

If prior attempt, date and description:

Risk rating (Select all that apply.)

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Risk of harm to others

If present, describe:

If prior attempt, date and description:

Risk rating (Select all that apply.):

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Psychosis

Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

If present, describe:

Symptoms (Select all that apply.):

☐ Auditory/visual hallucinations ☐ Paranoia

☐ Delusions ☐ Command hallucinations

Substance use

Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Substance (Select all that apply.):

☐ Alcohol ☐ Marijuana ☐ Cocaine

☐ PCP ☐ LSD ☐ Methamphetamines

☐ Opioids ☐ Barbiturates ☐ Benzodiazepines

☐ Other (Describe.):

Urine drug screen: ☐ Yes ☐ No ☐ Unknown

Result (if applicable): ☐ Positive (If selected, list drugs.): ☐ Negative ☐ Pending	
Blood alcohol level: ☐ Yes ☐ No ☐ Unknown	
Result (if applicable): ☐ Pending ☐ Value:	
Substance use screening (Select if applicable and give score.): ☐ CIWA: ☐ COWS:	
For substance use disorders, please complete the following additional information.	
Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (Describe or give symptoms.)	Risk rating
Dimension 1 (acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms)	☐ Minimal/none — not under influence; minimal withdrawal potential ☐ Mild — recent use but minimal withdrawal potential ☐ Moderate — recent use; needs 24-hour monitoring ☐ Significant — potential for or history of severe withdrawal; history of withdrawal seizures ☐ Severe — presents with severe withdrawal, current withdrawal seizures
Dimension 2 (biomedical conditions and complications)	☐ Minimal/none — none or insignificant medical problems ☐ Mild — mild medical problems that do not require special monitoring ☐ Moderate — medical condition requires monitoring but not intensive treatment ☐ Significant — medical condition has a significant impact on treatment and requires 24-hour monitoring ☐ Severe — medical condition requires intensive 24-hour medical management
Dimension 3 (emotional, behavioral or cognitive complications)	☐ Minimal/none — none or insignificant psychiatric or behavioral symptoms ☐ Mild — psychiatric or behavioral symptoms have minimal impact on treatment ☐ Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs ☐ Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24-hour monitoring ☐ Severe — active suicidal/homicidal ideations and

	plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management
Dimension 4 (readiness to change)	☐ Maintenance — engaged in treatment ☐ Action — committed to treatment and modifying behavior and surroundings ☐ Preparation — planning to take action and is Making adjustments to change behavior; has not resolved ambivalence ☐ Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change ☐ Precontemplative — in treatment due to external pressure; resistant to change
Dimension 5 (relapse, continued use or continued problem potential)	☐ Minimal/none — little likelihood of relapse ☐ Mild — recognizes triggers; uses coping skills ☐ Moderate — aware of potential triggers for MH/SA issues but requires close monitoring ☐ Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment ☐ Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences
Dimension 6 (recovery living environment)	☐ Minimal/none — supportive environment ☐ Mild — environmental support adequate but inconsistent ☐ Moderate — moderately supportive environment for MH/SA issues ☐ Significant — lack of support in environment or environment supports substance use ☐ Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abusive individual or active user; coping skills and recovery require a 24-hour setting
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	

Previous treatment (Include provider name, facility name, medications, specific treatment/levels of care and adherence.)
Current treatment plan
Standing medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
Support system (Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.)
Results of depression screening

Readmission within the last 30 days? ☐ Yes ☐ No If yes, and readmission was to the discharging facility, what part of the discharge plan did not work and why?
Initial discharge plan (List name and number of discharge planner and include whether the member can return to current residence.)
Planned discharge level of care:
Describe any barriers to discharge:

Expected discharge date:
Submitted by:
Phone:

Declaration for Mental Health Treatment Form

A Document to Help People Make Choices about Their Mental Health Treatment

The Tennessee Department of Mental Health and Developmental Disabilities developed this form based on Tennessee Code Annotated Title 33, Chapter 6, Part 10.

Introduction

The Tennessee mental health and developmental disability law gives the right to individuals 16 years of age and over to be involved in decisions about their mental health treatment. The law also recognizes that, at times, some individuals are unable to make treatment decisions. A Declaration for Mental Health Treatment allows persons receiving services to plan ahead; it may also assist service providers in giving appropriate treatment.

The Declaration for Mental Health Treatment form describes what a service recipient wants to occur when he/she receives mental health treatment. It describes mental health services that a service recipient might consider, the conditions under which the Declaration may be acted upon, and directions on how a service recipient can revoke a Declaration.

For example, completion of a Declaration for Mental Health Treatment form allows you to state:

- Conditions or symptoms that might cause the Declaration to be acted upon
- Medications you are willing to take and medications you are not willing to take
- Specific instructions for or against electroconvulsive or other convulsive treatment
- Mental health facilities and mental health providers which you prefer
- Treatments or actions which you will allow or those which you refuse to permit
- Any other matter pertaining to your mental health treatment which you wish to make known

Instructions

5. Please read the form carefully. See Declaration for Mental Health Treatment

6. Where there are places on the form that ask you to choose between two or more items, you must choose at least one. For example, the following statement from the form requires you to choose one of the options.

"If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:
You must check one.

❑ I do not have a preference regarding medications.

❑ I do not consent to the administration of the following medications."

1. Be as specific as possible when identifying your preferences.

2. Be sure to initial and date at the bottom of each page.

3. You must sign the form in front of two adult witnesses who know you.

4. You must discuss the contents of this form with the witnesses required to sign it.

5. It is highly recommended that you discuss the contents of this form with the significant persons in your life and your mental health service providers.

Declaration for Mental Health Treatment
*for*_____
Print Full Name

This Declaration states my wishes for the provision of mental health treatment when I am unable to make informed decisions about my mental health treatment. It is authorized by Tennessee Code Annotated Title 33, Chapter 6, Part 10.

I understand that I may become unable to make informed decisions about my mental health treatment due to symptoms of a diagnosed mental disorder. These symptoms may include:
_____
_____
_____

I recognize that I am able to state my treatment preferences in the following areas: psychoactive and other medications, electroconvulsive and other convulsive therapies, and psychiatric hospitalization for a maximum of fifteen (15) days. This Declaration may include consent to, or refusal to, permit mental health treatment and other instructions and information for mental health service providers.

Psychoactive and Other Medications

If I am unable to make mental health treatment decisions, my wishes regarding psychoactive and other medications are as follows:

You must check one.

❑ I do not have a preference regarding medications.

❑ I do not consent to the administration of the following medications.

Medication	Reason for Not Consenting

The following medications have worked for me.

Medication	

Conditions or Limitations: _____

_____

_____

*Admission to and Remaining in a Hospital for Mental Health Treatment**

If I am unable to make informed mental health treatment decisions, my wishes regarding admission to, or remaining in, a hospital are as follows:

You must check one.

❑ I do not have a preference regarding admission to a hospital for mental health treatment.

❑ I consent to being admitted to a hospital for mental health treatment.

❑ I do not consent to voluntary admission to a hospital.

If I am admitted to a hospital for mental health treatment:

You must check one.

❑ I consent to remain voluntarily in the hospital for mental health treatment.

❑ I do not consent to remain voluntarily in the hospital for mental health treatment.

Conditions or Limitations: _____

_____

_____

_____

_____

**Authorization under a Declaration is limited to 15 days for psychiatric hospitalization.*

Admission to and Continuation of Mental Health Services from Other Facilities

If I am unable to make informed mental health treatment decisions, my wishes about receiving mental health services, or continuation of services, are as follows:
You must check one.

- ❑ I do not have a preference about receiving mental health services from a facility, which is not a hospital.
- ❑ I consent to receiving services from a facility, which is not a hospital.
- ❑ I do not consent to receiving mental health services from a facility, which is not a hospital.

Conditions or Limitations: _____
_____
_____
_____

Treatment Provider or Facility
If I am unable to make informed mental health treatment decisions, my wishes regarding treatment providers or treatment facilities are as follows:

Check each that applies.

- ❑ I do not have a preference of providers or treatment facilities.
- ❑ I do not consent to receiving treatment by the listed providers or treatment facilities.
- ❑ I do prefer the following:

Providers

Do not consent	*Prefer*

Treatment Facility

Do not consent	*Prefer*

Conditions or Limitations: _____
_____
_____

Electroconvulsive and Other Convulsive Therapies

If I am unable to make informed mental health treatment decisions, my wishes regarding electroconvulsive and other convulsive therapies are as follows:

You must check one.

❑ I do not have a preference regarding electroconvulsive or other convulsive therapies.

❑ I do not consent to the administration of electroconvulsive or other convulsive therapies.

❑ I consent to electroconvulsive or other convulsive therapies, under the following conditions:

Conditions or Limitations: _____
_____
_____

Other Preferences

If I am unable to make informed mental health treatment decisions, my wishes regarding other information or preferences are listed below:

_____
_____
_____
_____
_____

If I am unable to make informed mental health treatment decisions, please inform one of the following:

Name _____ Area Code and Phone Number _____
_____ _____
_____ _____

My Affirmation

I am sixteen (16) years of age or older. I am capable of making informed mental health treatment decisions. I make this Declaration for Mental Health Treatment to be followed, if I become unable to make informed mental health treatment decisions. The determination that I am unable to make an informed decision about my mental health treatment must be made by (1) a court in a conservatorship or guardianship proceeding, or (2) two physicians, or (3) a physician with expertise in psychiatry and a doctoral level psychologist with health service provider designation.

I know that I may cancel this Declaration at any time, orally or in writing, when I am able to make informed treatment decisions.

This Declaration will expire two years from the day it is signed by me and the two witnesses or a shorter period specified by this date: _____.

I affirm that the preferences expressed in this document were made after due consideration and without coercion. I affirm that I have discussed this document with the witnesses.

Print Name _____
Signature _____ Date _____
Address _____
_____
Area Code and Phone Number _____
Date of Birth _____

Affirmation of First Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
The service recipient's mental health service provider; or
An employee of the service recipient's mental health service provider; or
The operator of a mental health facility; or
An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____
Address _____
Area Code and Phone Number _____
**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*
***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*
Affirmation of Second Witness

I affirm that _____ is personally known to me; that he/she signed this Declaration for Mental Health Treatment in my presence; that he/she talked to me about the document and its contents and the reasons for preparing and wanting the document to be effective. He/she appears to be able to make informed mental health treatment decisions and is not under duress, fraud or undue influence. The Declaration was not signed on the premises of a mental health service provider.

I affirm that I am an adult and that I am not:
The service recipient's mental health service provider; or
An employee of the service recipient's mental health service provider; or
The operator of a mental health facility; or
An employee of a mental health facility.

YOU MUST CHECK ONE

Yes ❑ No ❑ I am a relative by blood, marriage, or adoption.*

YOU MUST CHECK ONE

Yes ❑ No ❑ I am likely to be entitled to a portion of this person's estate in the event of his/her death.**

Signature _____ Date _____
Address _____
Area Code and Phone Number _____
**Only one of the two witnesses can be a relative by blood, marriage, or adoption.*
***Only one of the two witnesses can be a person likely to benefit from the death of the person completing the Declaration.*

Declaration for Mental Health Treatment

Tennessee Department of Mental Health. Authorization No. 339408, 10,000 copies, November 2001. This document was promulgated at a cost of $0.15 per copy.

Additional copies of this form may be obtained from the Tennessee Department of Mental Health website at tn.gov/mental.

For additional information contact the Tennessee Department of Mental Health Office of Consumer Affairs 800-560-5767. Document number MHDD-5067.

The Tennessee Department of Mental Health is committed to the principles of equal opportunity, equal access, and affirmative action. Contact the Department's EEO/AA Coordinator at (615) 532-6580, the Title VI Coordinator at (615) 532-6700 or the ADA Coordinator at (615) 532-6700 for further information. Persons with hearing impairments call (615) 532-6612.
Request for Authorization — Psychological Testing
Wellpoint — Behavioral Health Services
Telephone: 833-731-2154 Fax: 800-505-1193

Outpatient Treatment Report Form C

Outpatient Treatment Report Form C for BH: The behavioral health provider may use this form instead of calling Wellpoint to precertify outpatient behavioral health services.

Outpatient Treatment Report FORM C

Wellpoint
Telephone: 833-731-2154 Fax: 866-920-6006

FILL OUT COMPLETELY TO AVOID DELAYS
IDENTIFYING DATA
Patient's Name: _____ Medicaid #: _____ DOB: _____
Patient's Address: _____ State: _____ ZIP: _____

PROVIDER INFORMATION
Provider Name: _____ Tax ID #: _____
Phone #:_____ Fax #: _____
PCP Name: _____ Name of Other Behavioral Health Provider(s):_____
PCP NPI: _____

DSM-IV TR DIAGNOSIS
Axis I: _____ Axis II: _____ Axis III: _____
Avis IV: _____ Avis V Current: _____ Highest in Past Year: _____

CURRENT CLINICAL INFORMATION

Symptoms/Problems	Mild	Moderate	Severe	Acute	Chronic			Mild	Moderate	Severe	Acute	Chronic
Anxiety disorders							Psychotic disorders					
Obsessions/compulsions							Delusions/paranoia					
Generalized anxiety							Self-care issues					
Panic attacks							Hallucinations					
Phobias							Disorganized thought process					
Somatic complaints							Loose associations					
PTSD symptoms							Substance abuse					
Depression							Loss of control of dosage					
Impaired concentration							Amnesic episodes					
Impaired memory							Legal problems					
Psychomotor retardation							Alcohol abuse					

Sexual issues							Opiate abuse						
Appetite disturbance							Prescription medication abuse						
Irritability							Polysubstance abuse						
Agitation							Personality Disorder						
Sleep disturbance							Oddness/eccentricities						
Hopelessness/Helplessness							Oppositional						
Mania							Disregard for law						
Insomnia							Recurring self-injuries						
Grandiosity							Sense of entitlement						
Pressured speech							Passive aggressive						
Racing thoughts/flight of ideas							Dependency						
Poor judgment/impulsiveness							Enduring traits of:						

Patient Name: _____

MEDICATIONS (optional for nonphysicians)
Current Medications (indicate changes since last report)____Dosage_____Frequency_____
_____
_____
_____

CURRENT RISK FACTORS
Suicide: ☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm self

Homicide: ☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm others

Physical or Sexual Abuse or Child/Elder Neglect: ☐ Yes ☐ No

- If "Yes," patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family
- Abuse or neglect involves a child or elder: ☐ Yes ☐ No
- Abuse has been legally reported: ☐ Yes ☐ No

SYMPTOMS THAT ARE THE FOCUS OF CURRENT TREATMENT: _____
_____
_____

PROGRESS SINCE LAST REVIEW:

FUNCTIONAL IMPAIRMENTS OR SUPPORTS:

FAMILY/INTERPERSONAL RELATIONSHIPS:

JOB/SCHOOL:

HOUSING:

CO-OCCURRING MEDICAL/PHYSICAL ILLNESSES:

FAMILY HISTORY OF MENTAL ILLNESS:

Patient Name: _____

PATIENT'S TREATMENT HISTORY INCLUDING ALL LEVELS OF CARE:

Level of care	Number of distinct episodes/sessions of	Date of last episode/session		Level of care	Number of distinct episodes/sessions of	Date of last episode/session
Outpatient Psych				PHP		
Outpatient – substance abuse				Inpatient – psych RTC		
IOP				Inpatient – substance abuse		

TREATMENT GOALS:

1. _____
2. _____
3. _____

OBJECTIVE OUTCOME CRITERIA BY WHICH GOAL ACHIEVEMENT IS MEASURED:

1. _____
2. _____
3. _____

DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE:

_____
_____
_____
_____

EXPECTED OUTCOME AND PROGNOSIS

☐ Return to normal functioning.
☐ Expect improvement, anticipate less than normal functioning.
☐ Relieve acute symptoms, return to baseline functioning.
☐ Maintain current status, prevent deterioration.

RISK HISTORY: Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact patient's level of functioning.

_____
_____
_____
_____
_____
_____

REQUESTED AUTHORIZATION:

Procedure Code:_____	Number of Visits:_____	Frequency: _____	Units Approved: _____
Procedure Code:_____	Number of Visits:_____	Frequency: _____	Units Approved: _____
Procedure Code:_____	Number of Visits:_____	Frequency: _____	Units Approved: _____
Procedure Code:_____	Number of Visits:_____	Frequency: _____	Units Approved: _____
☐ Approved – Auth #:			

Provider's Signature: _____Date:_____

Disclaimer: Authorization indicates that Wellpoint determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

PATIENT NAME:

PATIENT'S TREATMENT HISTORY INCLUDING ALL LEVELS OF CARE:

Level of care	Number of distinct episodes/sessions of	Date of last episode/session		Level of care	Number of distinct episodes/ sessions of	Date of last episode/ session
Outpatient Psych				PHP		
Outpatient – substance abuse				Inpatient – psych RTC		
IOP				Inpatient – substance abuse		

TREATMENT GOALS:

1.
2.
3.

OBJECTIVE OUTCOME CRITERIA BY WHICH GOAL ACHIEVEMENT IS MEASURED:

1.
2.
3.

DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE:

EXPECTED OUTCOME AND PROGNOSIS:

- ❑ Return to normal functioning
- ❑ Expect improvement, anticipate less than normal functioning
- ❑ Relieve acute symptoms, return to baseline functioning
- ❑ Maintain current status, prevent deterioration

RISK HISTORY:

Explain any significant history of suicidal, homicidal, impulse control or any behavior that may impact patient's level of functioning:

REQUESTED AUTHORIZATION:

Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:
Procedure Code:	Number of Units:	Frequency:	Units Approved:

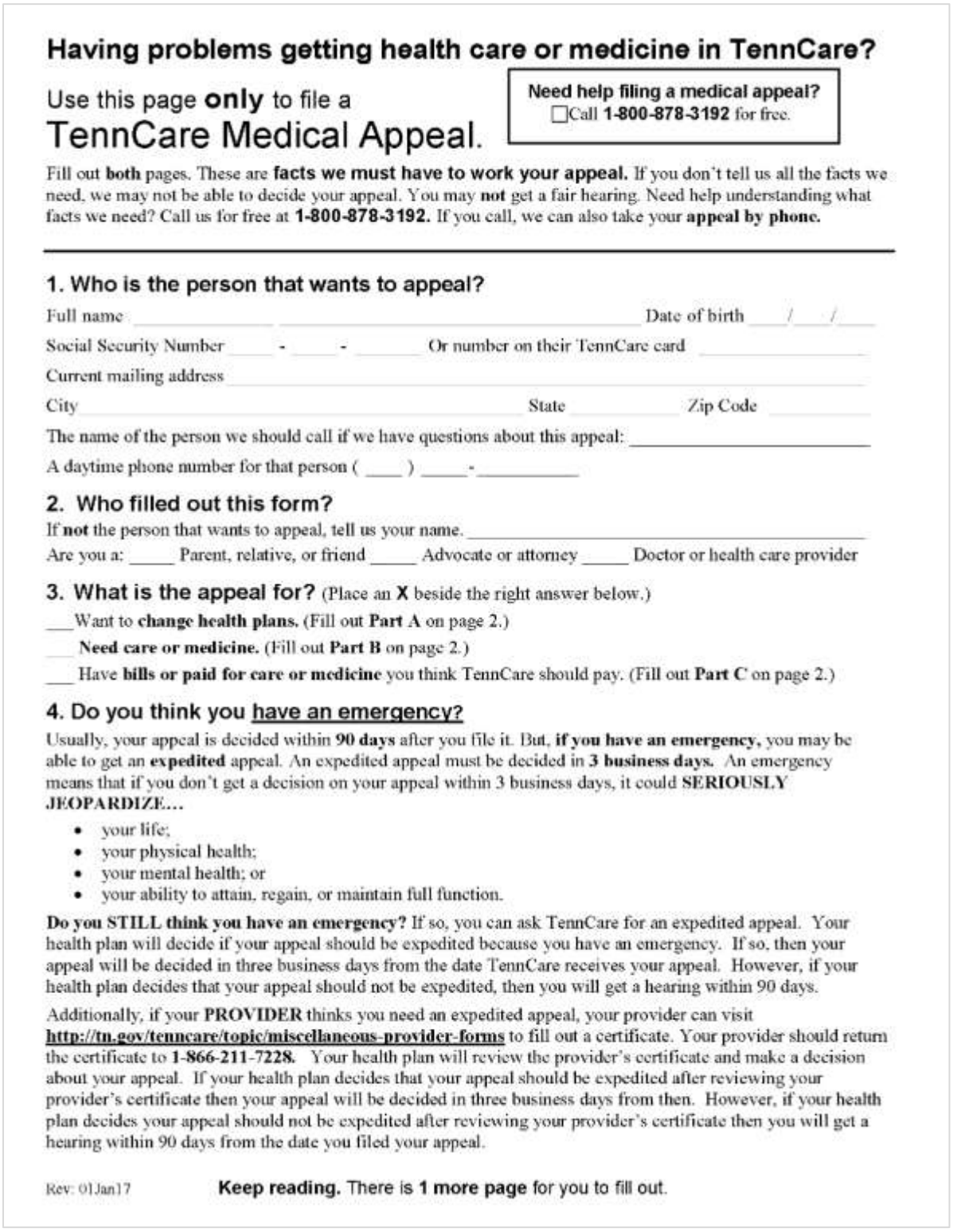
❑ Approved – Auth #:

PROVIDER'S SIGNATURE: **DATE:**

Disclaimer: Authorization indicates that AMERIGROUP determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

TennCare Medical Appeal Form

The TennCare Medical Appeal Form is located at:
tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal.html.



Having problems getting health care or medicine in TennCare?

Use this page **only** to file a
TennCare Medical Appeal.

Need help filing a medical appeal?
☐Call **1-800-878-3192** for free.

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

---

1. Who is the person that wants to appeal?

Full name _____ _____ Date of birth ___/___/___

Social Security Number ___ - ___ - ____ Or number on their TennCare card _____

Current mailing address _____

City _____ State _____ Zip Code _____

The name of the person we should call if we have questions about this appeal: _____

A daytime phone number for that person (___) ____-_____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. _____

Are you a: _____ Parent, relative, or friend _____ Advocate or attorney _____ Doctor or health care provider

3. What is the appeal for? (Place an **X** beside the right answer below.)

___Want to **change health plans.** (Fill out **Part A** on page 2.)

___ **Need care or medicine.** (Fill out **Part B** on page 2.)

___ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, **if you have an emergency,** you may be able to get an **expedited** appeal. An expedited appeal must be decided in **3 business days.** An emergency means that if you don't get a decision on your appeal within 3 business days, it could **SERIOUSLY JEOPARDIZE…**

- your life;
- your physical health;
- your mental health; or
- your ability to attain, regain, or maintain full function.

Do you STILL think you have an emergency? If so, you can ask TennCare for an expedited appeal. Your health plan will decide if your appeal should be expedited because you have an emergency. If so, then your appeal will be decided in three business days from the date TennCare receives your appeal. However, if your health plan decides that your appeal should not be expedited, then you will get a hearing within 90 days.

Additionally, if your **PROVIDER** thinks you need an expedited appeal, your provider can visit **http://tn.gov/tenncare/topic/miscellaneous-provider-forms** to fill out a certificate. Your provider should return the certificate to **1-866-211-7228.** Your health plan will review the provider's certificate and make a decision about your appeal. If your health plan decides that your appeal should be expedited after reviewing your provider's certificate then your appeal will be decided in three business days from then. However, if your health plan decides your appeal should not be expedited after reviewing your provider's certificate then you will get a hearing within 90 days from the date you filed your appeal.

Rev: 01Jan17 **Keep reading.** There is **1 more page** for you to fill out.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want _____

Part B. Need care or medicine. What kind - be specific _____

What's the problem? ___Can't get the care or medicine at all.
___Can't get as much of the care or medicine as I need.
___The care or medicine is being cut or stopped.
___Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ___Yes ___No If yes, doctor's name _____

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter _____

Who was the letter from? _____

Are you getting this care or medicine from TennCare now? ___ Yes ___ No

Do you want to see if you can keep getting it during your appeal? ___ Yes ___ No

Does your doctor say you still need it? ___ Yes ___ No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine _____ Name of doctor, drug store, or other place that gave you the care or medicine _____ Their phone number (__) _____-_____

Their address _____

Did you **pay for the care or medicine and want to be paid back?** ___ Yes ___ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ___ Yes ___ No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). _____

How to file your medical appeal

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:

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

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.
If you think you've been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**

Rev:01Jan17

Expedited TennCare Appeal Form

The Expedited TennCare Appeal Form is located at: tn.gov/tenncare/providers/tenncare-provider-news-notices-forms/miscellaneous-provider-forms.html.

Treating Provider's Certificate: *Expedited* TennCare Appeal

An expedited appeal is an administrative appeal for a medical service that must be either approved or denied within three (3) business days, 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."

To request an expedited appeal for your patient:

1. Read the statement below. If you agree, indicate your certification and sign and date in the spaces provided.

☐ I certify that I am the treating clinician of the patient named below, and that ***the acute presentation of this medical condition is of sufficient severity that the absence of a decision within three business days could seriously jeopardize the enrollee's life, physical health, or mental health or their ability to attain, regain, or maintain full function.***

Provider's Signature:_____ Date:_____

2. Identify the desired service:_____

3. Identify the patient.

_____

(Name) (SS#) **or** (date of birth)

4. At your discretion, please attach a narrative and/or medical records that support this request.

Fax this completed form and any accompanying documentation to the **Bureau 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.)

TC0181 (Rev. 28Dec.2016) RDA 2045

Provider Appeals Form

Appeal Form

Thank you for contacting Wellpoint. All nonexpedited appeals must be submitted in writing to the Wellpoint Centralized Appeals Team. This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely.

Note: Per Federal Privacy Regulations (HIPAA), Wellpoint can only accept an appeal from a provider appealing on behalf of a member if the member has issued a written statement naming that provider as his/her designated representative.

Member Information

Last Name: _____ First Name: _____
Member Number: _____
Address:_____
City:_____ State: _____ ZIP_____

Provider Information

Last Name: _____ First Name: _____
Facility _____
TIN: _____ Provider Number: _____
Address: _____
City:_____ State: _____ ZIP: _____

Claim Data (If Applicable)

Claim Number: _____ Authorization Number: _____
Date Service Started:_____ Date Service Ended:_____

Please provide an explanation of the appeal reason. Attach a separate sheet if additional space is needed:

_____
_____
_____
_____

Please place a check mark next to the items being submitted with the appeal.

__Copy of original claim
__Copy of the Wellpoint EOP
__EOP or EOB from another carrier
__Evidence of eligibility verification
__Medical records
__Approved referral and authorization forms from Wellpoint indicating the authorization number
__Contract rate sheets indicating evidence of payment rates
__Evidence of previous appeal submission or timely filing
__Letter from member designating provider as his/her designated representative

Appeals forms and supporting documentation should be addressed to:
Wellpoint Centralized Appeal Team
P.O. Box 61599
Virginia Beach, VA 23466-1599

Independent Review Forms

There are three different forms available to request an independent review:

1. The *Request to Commissioner for Independent Review of Disputed TennCare Claim* form can be electronically completed on the state's website at tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html.
2. The *Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim* form on the following page is a traditional form that can be printed and completed by the provider.
3. The *Request to Commissioner for Independent Review of Disputed TennCare Episode of Care Cycle Provider Gain/Risk Share Total* form, which is specific to requests related to disputes regarding the annual provider Episode of Care report, can be electronically completed on the state's website at tn.gov/commerce/tenncare-oversight/mco-dispute-resolution/independent-review-process.html

REQUEST to COMMISSIONER of COMMERCE & INSURANCE for INDEPENDENT REVIEW of DISPUTED TENNCARE CLAIM

TO: Compliance Officer, TennCare Division, Tenn. Dept. of Commerce & Insurance
500 James Robertson Parkway, 11th Floor, Nashville, TN 37243-1169
Telephone: (615) 741-2677 or Fax: (615) 401-6834

FROM: Provider Contact Person: _____
Mailing Address: _____
City, State, Zip Code: _____
Telephone: (_____) _____
Fax Number: (_____) _____
E-mail Address: _____

Fill out this form completely or it may be returned as ineligible. Read the attached Instruction Sheet for completing this form.
(Submit a separate request form for each claim unless claims will be aggregated. See # 14 below.)

1. Provider Name: _____ NPI#: _____
2. TennCare MCO that denied claim: _____
3. Date(s) of Service(s): _____
4. Enrollee Name & ID #: _____
5. Claim(s) Amount: _____
6. Initial claim(s) submission date: _____
7. **Attach submitted claim(s).**
8. Date MCO partially or totally denied payment of claim (s): _____
9. **Attach MCO written denial(s). [Claim(s) must be submitted to Independent Review within 365 days of the MCO's 1st denial.]**
10. Date Provider requested reconsideration in writing: _____. **(Reconsideration request is required, regardless of whether a denial was received.)**
11. **Attach copy of dated written reconsideration request.**
12. **Attach MCO's response to your reconsideration request if you received one.**
13. **Briefly** describe disputed claim. Description may include, but not limited to: reason given for denial and your position explaining why the MCO should pay the claim. _____
    _____
    _____
14. Do you want your claims aggregated? ___ Yes ___ No. Only claims involving a common question of fact or law may be aggregated. The fact that a claim is not paid does not create a common question of fact or law. If you wish to aggregate your claims, explain the common question of fact or law: _____
    _____
    _____

Only claims which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b)(2)(A) thru (D) are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible.

ACKNOWLEDGEMENT OF FEE OBLIGATION

By my signature below, I hereby request independent review of the above claim, pursuant to T.C.A. §§ 56-32-126(b) or 71-5-2314. I also confirm that the above mentioned disputed claim will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. Any provider who initiates independent review for a non-TennCare claim is ultimately responsible for paying the reviewer's fee. I also understand that there is a mandatory fee of $750.00 per claim and if I have a contract with the MCO, the MCO is initially responsible for paying the fee. I further understand that if the reviewer determines the MCO correctly denied payment of this disputed claim(s), then I must reimburse the MCO for the reviewer's fee as established by the Selection Panel for TennCare Reviewers.

15. Are you a contracted provider with the MCO? ___ Yes ___ No
16. **Attach evidence of contract.** (A copy of the signature page from the provider contract is sufficient.)
17. **If you do not have a contract with the MCO, you must submit the reviewer's fee with your request.** (Per claim, attach check for $750 made payable to the Department of Commerce and Insurance).
18. Amount of check sent to TN Dept. of Commerce and Insurance for the reviewer's fee: $_____

_____ _____
Signature (Name & Title) Date

_____
(Type or Print Name & Title)

Revised July 2015

Disclosure for Provider Entities

This information is required during the provider registration on the TennCare Web portal at tn.gov/tenncare/providers/provider-registration.html.

Practitioner Attestation Form

Practitioner Attestation:

I certify and attest that the following is true and correct. I understand that factual misrepresentation may result in my nonselection, or if discovered after selection, my termination, as a Wellpoint practitioner for the TENNCARE MANAGED CARE Program.

TennCare Rule 1200-13-1-05 (1.a.3.) requires that I disclose whether (i) I am under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, or (ii) I have been convicted of a criminal offense in any program under the Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs. Pursuant to Chapter 42 CFR Part 455, Subpart B State plans require disclosure of information regarding a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, and the Title XX Programs.

Wellpoint is required to disclose to TENNCARE, the Comptroller General and CMS full and complete information regarding persons convicted of criminal activity related to Medicare, Medicaid, or Federal Title XX programs in accordance with federal and State requirements, including Public Chapter 379 of the Acts of 1999.

I, _____, hereby certify and attest that I have not been convicted of fraud, or any other criminal offense in connection with obtaining or attempting to obtain, or performing a public (federal, State, or Local) transaction or grant under a public transaction, a violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property, nor have I had a civil judgment rendered against me for commission of any of the above offenses. I am not under a federal Drug Enforcement Agency (DEA) restriction of my prescribing and/or dispensing certification for scheduled drugs, and I have not been convicted of a criminal offense in any program under Medicare, Medicaid, or the Federal Title XX services program since the inception of those programs.

By: _____
Please Type or write name

_____
Signature

_____
Date

_____
Title-Position

_____
Practice-Facility-Affiliation

_____
Tax Identification Number

Provider Payment Dispute and Correspondence - Submission Form

This form should be completed by Tennessee Providers for Payment Disputes and Claim Correspondence only.

Member First/Last Name 1 _____ Member DOB 2 _____

AMERIGROUP, Medicaid or Medicare (circle one) Member # 3 _____

Provider First/Last Name 4 _____ Provider # 5 _____

Provider Contact First/Last Name 6 _____ Contact Phone (___) 7 _____

8 ☐ Participating

☐ Non-Participating: If filing for a Medicare member and the member has potential financial liability, you must include a completed CMS Waiver of Liability form.

Provider Street Address 9a _____

City 9b _____ State 9c Zip 9d Phone (_____) 9e _____

Claim # 10 _____ Billed Amount $ 11 _____ Amount Received $ 12 _____

Start Date of Service 13 _____ End Date of Service 14 _____ Auth # 15 _____

In accordance with Tennessee regulation , providers have an external independent review process available if you continue to disagree with a payment decision after receiving a decision from a health plan's internal dispute process. For specific instructions and requirements for this process, please review the Tennessee regulation. A form for filing is located at . Please be aware there is a fee associated with each claim requested for review that must be paid by the provider if the external reviewer upholds our determination. Please note this process is not applicable to Medicare member's liability denials.

PAYMENT DISPUTE

A payment dispute is defined as a dispute between the provider and AMERIGROUP in reference to a claim determination where the member cannot be held financially liable. All disputes with member liability must follow the applicable appeals process. Please refer to the explanation of payment to ensure you are following the correct process.

16 Clearly and completely indicate the payment dispute reason(s). You may attach an additional sheet if necessary. **Please include appropriate medical records.**

_____

_____

_____

17 **CLAIM CORRESPONDENCE:** Check (√) appropriate box below.

Claim correspondence is defined as a request for additional/needed information in order for a claim to be considered clean, to be processed correctly or for a payment determination to be made.

☐ **Itemized Bill/Medical Records** (In response to an AMERIGROUP claim denial or request)

☐ **Corrected Claim** ☐ **Other Insurance/Third-Party Liability Information** ☐ **Other Correspondence**

18 Clearly and completely http://www.tn.gov/tncoversight/PCIR.shtml. t if necessary.

_____

_____

Mail this form and supporting documentation to:

19

AMERIGROUP Community Care
Payment Disputes
PO Box 61599
Virginia Beach, VA 23466-1599

How to complete the Provider Payment Dispute Form

Use the Provider Payment Dispute Form to request payment reconsideration for any claim(s) that have been previously denied or underpaid by Wellpoint.

1. Insert Member Name for claim(s) in dispute
2. Insert Member Date of Birth for claim(s) in dispute
3. Insert Wellpoint Medicaid or Medicare Member number for claim(s) in dispute. Circle type of ID applicable for member
4. Insert Provider First and Last Name disputing the claim(s)
5. Insert Provider Number for provider disputing the claim(s)
6. Insert Contact First and Last Name who is familiar with the disputed claim(s) and should receive correspondence regarding the dispute being submitted
7. Insert Contact Phone Number to be reached between the hours of 8:00 a.m. – 5:00 p.m. Monday – Friday
8. Check applicable box indicating whether Provider disputing claim(s) is Par (In Network) or Non-Par (Out of Network)
9. (a-e) Insert Provider Street Address, City, State, ZIP Code and Phone Number
10. Insert the Claim(s) Number of claim(s) in dispute — Attach a separate sheet if additional claim(s) with the same issue are being disputed
11. Insert Billed Amount for claim(s) in dispute
12. Insert Amount Received (Paid Amount) for claim(s) in dispute
13. Insert the Start Date of Service (Earliest date shown from the claim(s) in dispute)
14. Insert the End Date of Service (Latest date shown from the claim(s) in dispute)
15. Insert the Authorization Number the disputed claim(s) falls under if applicable
16. Check applicable box indicating if this is a First Level or Second Level payment dispute.
    a. First Level – Claim(s) have never been submitted for dispute.
    b. Second Level – Claim(s) sent for First Level Dispute was denied and the provider received a First Level Dispute determination letter; Second Level Dispute is being submitted for reconsideration.
17. Indicate a brief description of the reason(s) claim(s) is being disputed. Attach an additional page if necessary. Also, include appropriate medical records
18. Check applicable box indicating what type of correspondence is being submitted
19. Indicate reason(s) for the correspondence clearly and completely. Attach an additional page if necessary
20. Mail Provider Dispute Form and all supporting documentation to address given

Adverse Occurrence Reporting Form

TennCare Behavioral Health Adverse Occurrence Report

Provider Name:	Consumer Name: (Last, First)
Name of Reporting Person:	Address:
Name/Title of Person Submitting Report:	SSN:
Contact Number:	DOB:
Date Reported:	Date of Incident:
	MCO: ☐ UHCCP ☐ Wellpoint ☐ BlueCare ☐ TennCare Select
Persons Involved (Check all that apply) ☐ Clients ☐ Staff ☐ Persons Not Associated with Facility ☐ Other _____	Location of Incident ☐ Residential _____ ☐ Inpatient _____ ☐ Crisis Stabilization Unit (CSU) ____ ☐ Supported Housing
Type of Behavioral Health Adverse Occurrence (Check One) ☐ Suicide Death ☐ Non-Suicide Death ☐ Death-Cause Unknown ☐ Homicide ☐ Homicide Attempt w/significant medical intervention* ☐ Suicide Attempt w/significant medical intervention*	☐ Allegation of Abuse/Neglect-Including Peer to Peer (Physical, Sexual, Verbal) ☐ Accidental Injury w/significant medical intervention* ☐ Use of Restraints/Seclusion (Physical, Chemical, Mechanical) requiring significant medical intervention* ☐ Treatment Complications (medications errors and adverse medication reaction) requiring significant medical intervention* *Significant Medical Intervention: Requiring an ER visit or inpatient hospital stay
Summary of Adverse Occurrence: (Be specific, precise and as detailed as possible)	

Summary of Action Taken by Facility/Provider:	☐ Notified Parents or Next of Kin
☐ Notified 911	☐ Staff Debriefing/Training
☐ Taken to Physician	☐ Reported to DHS (Date)
☐ Taken to Hospital	☐ Reported to DCS (Date)
☐ Notified Fire Department	☐ Other
☐ Notified Police	(Specify) _____
☐ Notified Mental Health Case Manager	_____

MCO USE ONLY

Summary of MCO follow up actions to address reported adverse occurrence: (Please be specific, precise and detailed as possible)
Wellpoint has received notification of this AO and will follow up with provider as appropriate. Wellpoint will work with provider surrounding any issues identified.

FAX TO: 877-423-9976

The Language and Communication Assistance (LCAS) Notice and Nondiscrimination Notice set out below must be posted in 20–point sans serif font in your physical locations where it is reasonable to expect individuals seeking service from the health program or activity to be able to clearly read or hear the notice. Please add your contact information to the notice templates. The federal nondiscrimination laws contain notice requirements, you should review these laws to determine your compliance obligations.

Language and Communication Assistance (LCAS) Notice

Do you need free language or an auxiliary aid or service?
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. We have free auxiliary aids and services, like large print, to communicate effectively with you. Call us at 833-731-2153 (TRS: 711)
Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 833-731-2153 (TRS 711).
Arabic: ربيةلعا اذا متتكلا ةللغا ربيةلعا اتمدخ دةعالمسا ويةللغا رةفومتكلا انجام. اتصل مقبر: 833-731-2153 (TRS 711) وظةملحا:
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 833-731-2153 (TRS 711)
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 833-731-2153 (TRS 711)
Korean: 한국어 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 833-731-2153 (TRS 711) 번으로 전화해 주십시오.
French: Français ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 833-731-2153 (TRS 711).
Amharic: አማርኛ ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 833-731-2153 (TRS 711) .
Gujarati: ગુજરાતી સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 833-731-2153 (TRS 711).

Laotian: ພາສາລາວ ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 833-731-2153 (TRS 711).
German: Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 833-731-2153 (TRS 711).
Tagalog: Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 833-731-2153 (TRS 711).
Hindi: हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।833-731-2153 (TRS 711) पर कॉल करें।
Russian: Русский ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 833-731-2153 (TRS 711).
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 833-731-2153 (TRS 711). تماس بگیرید.

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.

APPENDIX B — CLINICAL PRACTICE GUIDELINES

Based on the health care needs of the member population and opportunities for improvement identified through the QM program, clinical practice and preventive health guidelines are adopted by the health plan. These guidelines are reviewed, revised and approved at least every two years using nationally recognized evidenced-based literature and developed through a collaborative review process. This review process involves both board-certified and credentialing network practitioners from appropriate specialties and internal medical directors. The guidelines are available online at provider.wellpoint.com/tn.

We continuously look for ways to assist you in improving the care provided to your Wellpoint patients. As the CPGs tend to be updated more frequently than the provider manual, having them available online ensures you will always be able to access the most current information. A full copy of the manual can also be downloaded from the provider website.

APPENDIX C — TENNCARE REGULATORY REQUIREMENTS

Wellpoint will not reimburse providers based on automatic escalators or linkages to other methodologies that escalate, such as current Medicare rates or inflation indexes, unless otherwise allowed by TennCare as specified in Section A.2.13.2.2 of the CRA.
Additional provider requirements are set forth in this Appendix. Contracting providers agree to comply with the language requirements set forth in the Medicaid Addendum in addition to the provisions of their Wellpoint Participating Provider Agreement. Required language can be updated by inclusion in the provider manual as referenced in Article II Section 2.2 of the Wellpoint Participating Provider Agreement. If any requirement in this Appendix conflicts with a provision of the Wellpoint Participating Provider Agreement, the terms of the Wellpoint Participating Provider Agreement shall govern, unless the provider manual terms are mandated by a program.

provider.wellpoint.com/tn

Medicaid services provided by Wellpoint Tennessee, Inc. We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call **833-731-2154**. Information about the civil rights laws can be found at **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.

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