If you, the provider, require verbal communication regarding matters in a language other than English, please call us at 800-690-1606 and we will provide you with the language assistance so that we can best serve you. You can also dial 711 for TTY assistance. Additionally, if you require UnitedHealthcare materials in alternate formats, please call us at 800-690-1606 to make such a request (e.g. provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).
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I. Welcome to UnitedHealthcare Community Plan

Welcome to the UnitedHealthcare Plan of the River Valley, Inc. (UPRV) network. This Provider Administration Manual shall be used as a comprehensive reference source for the information you and your staff need in order to conduct your interactions and transactions with us in the quickest and most efficient manner possible. Our goal is to ensure our members have convenient access to high quality care that is provided according to the most current and effective treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

A. TennCare Program

The TennCare program is the Tennessee State Medicaid program. It has been operating under a waiver from CMS since 1994 to offer coverage to the traditional Medicaid eligible population (TennCare Medicaid) as well as an expanded population (TennCare Standard). Most TennCare members are mothers and children, with 50 percent of the population under age 21. All TennCare members are enrolled into a Managed Care Organization (MCO) within their geographic region. The State of Tennessee is broken into three (3) geographic regions as shown in the following map:

UPRV has entered into a Contractor Risk Agreement (CRA) for each Grand Region with the State of Tennessee for provision of the TennCare benefits. The TennCare Program in each Grand Region is governed by its Contractor Risk Agreement, the TennCare Rules and Regulations as well as the TennCare Policies. The Bureau of TennCare website contains links to all governing documents as specified below:

TennCare Policies – http://www.tn.gov/tenncare/topic/policies

B. Description of our Health Plan Programs

UPRV administers the TennCare program as an MCO in all three (3) geographic regions doing business as UnitedHealthcare Community Plan (UHCCP). We are part of the government programs division of UnitedHealth Group serving over 3 million beneficiaries of public sector health care programs in 26 states and the District of Columbia.

UHCCP is a Primary Care Practitioner (PCP)-driven HMO network focusing on PCPs providing appropriate care to members in accordance with established clinical guidelines. UHCCP operates in an integrated model where all physical, behavioral and long term services and supports healthcare needs are assessed, coordinated, and monitored. This meets all of the needs of the member and allows for better medical management. UHCCP offers its members and providers programs in medical management, quality improvement, education and development, as well as quality customer service. The customer service areas are designed to provide efficient access and assistance to our providers and members.
Certain TennCare members are also eligible to receive enhanced services provided through the CHOICES benefit program. CHOICES is the Long Term Services and Supports program which works to promote quality and cost-effective coordination of care for CHOICES members with chronic, complex and complicated healthcare, social service and custodial needs. The CHOICES program includes both Nursing Facility and Home and Community Based (“HCBS”) care coordination. CHOICES care coordination operates in accordance with our fully integrated model so that the physical, behavioral and long term services and supports care health needs of the CHOICES members are met. Detailed information on the CHOICES program can be found in chapter XX of the Manual.
II. Introduction

A. Important Information Regarding the Use of this Guide

This Manual shall serve as a comprehensive guide regarding the policies and procedures by which you should administer care to all TennCare members including the CHOICES members. This Manual contains all information relating to physical, behavioral and long term services and supports.

PLEASE NOTE: If you are a routine vision provider, please refer to the March Vision Provider Manual which can be found on the UHCCP website at: http://www.uhcommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-ProviderReferenceGuide.pdf.

Ophthalmologists who are rendering medical services to UHCCP members should refer to this Manual.

All information defined in this Manual is considered a contractual obligation as stated in your Provider Agreement. Any revisions to this Manual shall be communicated to all participating providers at least 30 days prior to implementation in accordance with the Provider Agreement. This excludes any medical policy changes or required regulatory updates.

Specific language is required in TennCare provider agreements by the Bureau of TennCare. As noted in the Modification Section of your provider agreement, Bureau of TennCare required language and State of Tennessee mandates regarding the TennCare program can be updated by inclusion in the Manual. For ease of provider review, certain required language and TennCare program mandates are contained in a document titled “TennCare Regulatory Appendix, Bureau of TennCare Required Language–Provider Agreements” (See Appendix). This Appendix is routinely appended to UHCCP TennCare Provider Agreements. The latest version of this Appendix is also appended to this Manual. When UHCCP amends your Provider Agreement in order 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 UHCCP to make changes to confidential portions of your Provider Agreement, such as the payment provisions. When this type of change is required, UHCCP may provide you 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, UHCCP will limit such changes to those required to comply with the change in regulatory requirements.

B. Communications to Providers

From time to time, there may be important information about policies and protocols that must be communicated to all participating providers. These communications may be done through Network Bulletins, e-Alert or through the Practice Matters Provider Newsletter. If the information communicated through these methods is a change to any protocol set forth in this Manual, you will see the updated information in this Manual upon the next provider manual revision notification.

• **Network Bulletin** – The Network Bulletin is a monthly publication (12 times a year). This bulletin contains medical policy and reimbursement policy updates as well as administrative changes for all providers, not just Medicare and Medicaid. Articles located in this bulletin that are specific to TennCare providers will also be communicated through the Provider Newsletter – Practice Matters. The Network Bulletins can be found at [www.UnitedHealthcareOnline.com](http://www.UnitedHealthcareOnline.com) > Tools and Resources > News > Network Bulletin.

• **Practice Matters** – Practice Matters is the Provider Newsletter published quarterly specific to the TennCare product within UHCCP. This newsletter includes any policy changes and communicates any clinical topics or reminders. Articles regarding policy or administrative updates will be included in this publication but may also be found in the Network Bulletin as specified above. The Practice Matters newsletters are posted on the UHCCP provider website.
every March, June, September and December. They can be found at:
http://www.uhccommunityplan.com/health-professionals/TN/provider-news

• e-Alert – Providers also receive communications via e-Alert. This method of communication is used on an as-needed basis if there are reminders about educational opportunities or upcoming health fairs. It may also be used to reinforce communications from the Network Bulletin, Practice Matters newsletter or information posted on the provider website. Providers can request to receive e-alerts through their UHCCP Provider Advocate. If you miss an e-Alert, they are posted on the UHCCP provider website at:
http://www.uhccommunityplan.com/health-professionals/TN/provider-bulletins

1. UHCCommunityPlan.com

As our valued health care partner, we know your time is important. That’s why we’re providing you with free access to UnitedHealthcare Community Plan Online – available online 24 hours a day to provide you with time and cost-saving tools to help you manage operations.

1.1 How to Obtain a Username and Password

• To register for UHCCommunityPlan.com, please do the following:

• To access the non-secured portion of the website, go to UHCCommunityPlan.com > For Health Care Professionals > Select your State > Tennessee. This brings you to the general home page. Here you can access our policies (including the Reimbursement Policies), Provider Administration Manual, handouts, forms, and recent newsletters and e-Alert notices.

1.2 Overview of Website Functions

Registered users can use UHCCommunityPlan.com to:

• View claim status and submit claims for review (Please note: UHCCommunityPlan.com screen prints are not an acceptable form of documentation for timely filing payment reconsideration.)

• View PCP panel rosters

• Submit and view notification and authorization requests for medical health and radiology services

• Link to TennCare Kids EPSDT screening report, Preventative Health Measures Report, Provider Profile Summary, Health Risk Assessment, and Claims Trend Report
UHCCommunityPlan.com offers providers many convenient options to ensure quality service to the members. One option allows the provider to search by member for both the TennCare Kids EPSDT Screening Measures Report and the Preventive Health Screening Measures Report. These reports provide both comprehensive panel and member specific updates related to critical EPSDT as well as preventive service status for all of your UHCCP members. Services rendered and detailed within these reports align with Healthplan Effectiveness and Data Information Set (HEDIS) measures, which identify member care opportunities. Not only a demonstration of provider commitment to quality care, these evidence based services are often correlated with member satisfaction with his/her health care.

Click on either the "TennCare Kids EPSDT Report by Member" link or "PHM Report by Member" link to view an individual report for a member enrolled in your panel. Providers can search for an individual member by UHCCP Member ID Number or by Member First Name, Last Name, and Date of Birth. Searching by Member ID Number is the fastest and most accurate search method.

Another feature allows the provider to contact UHCCP through the online portal with questions regarding data on the TennCare Kids EPSDT or Preventive Health Measures report, such as dates of screening. The goal is to facilitate communication relating to reports that are available for providers. To submit a query or comment to UHCCP, you will need to click the “notify plan” link, enter the comment or question relating to the TennCare Kids EPSDT Screening or Preventive Health Screening Measures Report and submit the form. An e-mail will be sent to the EPSDT/Preventive Health and Education Department and providers will receive a reply within three (3) to five (5) business days.

For training requests, and any questions relating to UHCCommunityPlan.com features, please contact your Provider Advocate directly or send an e-mail to: UHC_TN_Outreach@uhc.com. UHCCP values your feedback and welcomes any suggestions to improve our online services.
C. General Information

1. Key Contact Information

Key Contact Information is included below however for your convenience, UHCCP has included a Provider Quick Reference Guide in the Forms Appendix. This Provider Quick Reference Guide can also be found at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-QRG.pdf.

Behavioral Health Crisis Services

For Adult (18 years and older) – Call 855 CRISIS 1 (Or 855-374-7471)

For Children (under 18 years of age) – Please refer to the information below:

![12 Crisis Service Regions](image)

Region 1: Frontier Health 877-928-9062
Region 2: Youth Villages 1-866-791-9223
Region 3: Helen Ross McNabb 865-539-2409
Region 4: Youth Villages 1-866-791-9224
Region 5: Youth Villages
  • Upper Cumberland 1-866-791-9223
  • Southeast 1-866-791-9225

Region 6: Mental Health Cooperative 615-726-0125
Region 7: Youth Villages 1-866-791-9222
Region 8: Youth Villages 1-866-791-9227
Region 9: Youth Villages 1-866-791-9227
Region 10: Youth Villages 1-866-791-9227
Region 11: Youth Villages 1-866-791-9227
Region 12: Youth Villages 1-866-791-9226

For Mobile Crisis Units, refer to the State of Tennessee Website: http://tn.gov/mental/recovery/crisis_serv.html
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<th>CONTACT</th>
<th>PHONE NUMBER</th>
<th>ADDITIONAL INFORMATION</th>
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<tr>
<td>Provider Services</td>
<td>800-690-1606</td>
<td>Hours of Availability: 8am-6pm EST Monday - Friday</td>
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<td>• Behavioral</td>
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<td>• Benefits &amp; Eligibility</td>
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<td>• Claims</td>
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<td>• Medical Management Services</td>
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<td>(including prior authorization)</td>
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<td>Provider Advocates</td>
<td>800-690-1606</td>
<td>In Network Providers, email at: <a href="mailto:UHC_TN_Outreach@uhc.com">UHC_TN_Outreach@uhc.com</a> Or fax at: 888-808-4420</td>
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<td>(Choose Provider option,</td>
<td></td>
<td>Out of Network Providers, email at: <a href="mailto:UHCCP_TN_Outreach@uhc.com">UHCCP_TN_Outreach@uhc.com</a> Or fax at: 888-823-7285</td>
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<td>enter Tax ID, enter specific</td>
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<tr>
<td>Member ID or wait for</td>
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<tr>
<td>Customer Service Representative to request call from appropriate Provider Advocate)</td>
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<tr>
<td>Nurse Help Line</td>
<td>866-263-9168</td>
<td>Hours of Availability: 24 Hours/7 Days aWeek</td>
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<td>DentaQuest</td>
<td>800-417-7140</td>
<td><a href="http://www.dentaquest.com">www.dentaquest.com</a></td>
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<td>• Dental coverage for TennCare members under 21 years of age</td>
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<td>Magellan</td>
<td>Pharmacy Helpdesk: 866-434-5520</td>
<td><a href="https://tenncare.magellanhealth.com/">https://tenncare.magellanhealth.com/</a></td>
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<td>• TennCare Pharmacy Benefits Manager</td>
<td>Clinical Call Center: 866-434-5524</td>
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<td>• TennCare Pharmacy Program</td>
<td>Clinical Fax 866-434-5523</td>
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<tr>
<td>TennCare Contact</td>
<td>888-816-1680</td>
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<td>• Family Assistance Service Center</td>
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<td>Non-Emergent Transportation</td>
<td>866-405-0238</td>
<td></td>
</tr>
<tr>
<td>TennCare Contact</td>
<td>866-311-4287</td>
<td></td>
</tr>
<tr>
<td>• Family Assistance Service Center</td>
<td>800-878-3192</td>
<td></td>
</tr>
<tr>
<td>• TennCare Solutions</td>
<td>800-758-1638</td>
<td></td>
</tr>
<tr>
<td>• TennCare Advocacy Program</td>
<td>800-852-2683</td>
<td></td>
</tr>
<tr>
<td>• Medicare/Medicaid Crossover Claims Unit</td>
<td>800-852-2683</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>800-633-4227</td>
<td></td>
</tr>
<tr>
<td>Fraud and Abuse Reporting</td>
<td>800-690-1606</td>
<td><a href="http://tn.gov/tenncare/section/fraud-and-abuse">http://tn.gov/tenncare/section/fraud-and-abuse</a></td>
</tr>
<tr>
<td>• UHCCP Tip Line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bureau of TennCare &amp; Office of Inspector General</td>
<td>800-433-3982</td>
<td></td>
</tr>
<tr>
<td>TennCare Foreign Language Line</td>
<td>800-758-1638</td>
<td></td>
</tr>
<tr>
<td>• Arabic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bosnian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kurdish-Badinani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kurdish-Sorani</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Somali</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Español (Spanish)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vietnamese</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee Relay Services for Hearing Impaired</td>
<td>Dial 711</td>
<td></td>
</tr>
</tbody>
</table>
2. Medical Referrals

There is no requirement to complete a written referral form when referring to a participating specialist or to any emergency room. PCPs are the medical home for the UHCCP members and should be involved of all aspects of the member’s care including making the appropriate appointments to participating specialists.

3. Prior Authorization

Chapter IX of this Manual, Utilization Management, includes a listing of selected services requiring prior authorization. Prior Authorization services for routine physical and behavioral health services can be requested by calling UHCCP Monday through Friday, 8 a.m. through 6 p.m. (EST) at 800-690-1606 or by faxing the prior authorization request form to 800-743-6829. The prior authorization form for medical services can be found in the Forms Appendix of this Manual or at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-PriorAuthFaxForm.pdf. The prior authorization form for behavioral health services can be found in the Forms Appendix of this Manual or at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN_BH_Prior_Auth_Concurrent_Review_Form.pdf.

For Prior Authorization of Behavioral Health emergency and urgent services, UHCCP staff is available at 800-690-1606 24 hours a day, 7 days a week. Physical health emergency medical services do not require prior authorization.

UHCCP offices will be closed on the following holidays: New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day, and New Year’s Eve Day.

4. Quick Reference Guide

Provider and member appeals are not processed in the same manner. Using the correct address to file any appeal or complaint, member or provider, will ensure a timely response. The following chart is designed to provide direction in determining the correct address for both:

<table>
<thead>
<tr>
<th>APPEAL REASON</th>
<th>APPEAL REQUESTER</th>
<th>APPEAL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denials that state a service is Not Medically Necessary, e.g., admissions and facility continuation care. (See Section IX, Utilization Management for details relating to medical necessity determinations.)</td>
<td>Provider</td>
<td>UnitedHealthcare Community Plan Provider Dispute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 5220</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston, NY 12402-5220</td>
</tr>
<tr>
<td>Issues regarding claims, accounts receivable, denials for no referral, member benefits, member eligibility and referral status. (See Chapter VI, Section C Provider Dispute Processes)</td>
<td>Provider</td>
<td>UnitedHealthcare Community Plan Provider Dispute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 5220</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston, NY 12402-5220</td>
</tr>
<tr>
<td>Denials that are upheld through the above noted processes may be submitted through the Provider Dispute Resolution process. (See Chapter VI, Section C Provider Dispute Processes)</td>
<td>Provider</td>
<td>UnitedHealthcare Community Plan Provider Dispute</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 5220</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kingston, NY 12402-5220</td>
</tr>
<tr>
<td>Delays, denials, reduction, suspension, or termination of services for members (See Chapter IV, Section D Member Appeals)</td>
<td>Member (Includes provider-assisted with member signature)</td>
<td>TennCare Solutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PO Box 593</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nashville, TN 37202-0593</td>
</tr>
</tbody>
</table>
D. Administrative Functions

1. Regulatory Compliance

UHCCP is dedicated to conducting business honestly and ethically with members, providers, suppliers and governmental officials and agencies. The need to make sound, ethical decisions as we interact with physicians, other health care providers, regulators and others has never been greater. It’s not only the right thing to do; it is necessary for our continued success and that of our business associates.

Compliance Program

As a business segment of UnitedHealth Group, UHCCP implements and is governed by the UnitedHealth Group Ethics and Compliance Program. The Compliance Program is a comprehensive program designed to educate all employees regarding the ethical standards that guide our operations, provide methods for reporting inappropriate practices or behavior, and procedures for investigation of and corrective action for any unlawful or inappropriate activity. The UnitedHealth Group Ethics and Compliance Program incorporates the required seven core elements of a compliance program as outlined by the U.S. Sentencing Guidelines:

- Oversight of the Ethics and Compliance Program,
- Development and implementation of ethical standards and business conduct policies,
- Creating awareness of the standards and policies through education,
- Assessing compliance by monitoring and auditing,
- Responding to allegations or information regarding violations,
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty,
- Reporting mechanisms for employees, managers and others to alert management and/or Compliance Program staff to violations of law, regulations, policies and procedures, or contractual obligations.

UHCCP has compliance program staff, led by the Chief Medicaid Compliance Officer, which is responsible for oversight and management of the Compliance Program for all UHCCP health plans. A Compliance Committee, consisting of senior managers from each of our key organizational functions, provides direction and oversight for the program. UHCCP also has local Compliance Officers and compliance contacts who report to the senior management as well as chair a state specific Compliance Committee to provide local oversight.

2. Fair Treatment and Translation Requirements

2.1 Notice about Non-Discrimination

No person, on the grounds of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classification protected by the applicable federal and state civil rights laws shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or service provided in the TennCare Program. Providers shall post notices of non-discrimination in conspicuous places, available to all employees and applicants, and shall be able to show proof that these notices are posted.

All organizations that participate in programs that receive Federal and state funds programs must obey the applicable Federal and state civil rights laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.
Any member who feels he/she has been discriminated against, or anyone that witnesses a discriminatory practice, should be encouraged to file a complaint. A copy of the unfair treatment form is available on the state website at http://www.tn.gov/assets/entities/tenncare/attachments/complaintform.pdf, and a copy of the unfair treatment form in Spanish is available on the state website at http://www.tn.gov/assets/entities/tenncare/attachments/complaintformSP.pdf. Both forms are also available in the Forms Appendix of this Manual as well as the Member Handbook.

If someone would like to file a complaint and needs help they can contact TennCare at:

**TennCare Office of Nondiscrimination Contract Compliance**

By Phone:
615-507-6474 or for free at 855-857-1673
For free TTY dial/lamar at 711 and ask for 855-857-1673

By Mail:
310 Great Circle Road, 4th Floor
Nashville, TN 37243
Fax: 1-615-253-2917

By Email:
hcfa.fairtreatment@tn.gov

Or a person may mail a completed complaint form to TennCare at this same address. A person can also call the Customer Service at 1-800-690-1606 for help or can mail a completed complaint form to UHCCP and UHCCP will mail the complaint to TennCare.

### 2.2 Fair Treatment and Translation Request for TennCare Members

TennCare members have the right to equal access to appointment times and are not to be subjected to extended wait times as compared to patients with other types of insurance. Members are to be given assistance with interpretation or translation services as necessary, and provided with proper accommodations for any disabilities.

Some members may have difficulties in speaking, reading, writing, or understanding the English language. This may result in impaired access to TennCare services. All TennCare members have a right to receive free interpretation and translations as Limited English Proficiency (LEP) services, available under state and Federal law. Providers are responsible for implementing policies and procedures for the provision of language assistance, interpretation, and translation services to any member who needs such services, including members with limited English proficiency and members who are hearing impaired; 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. This is a requirement which applies to any provider that accepts TennCare funds. UHCCP provides translation services to any of its members during direct contacts with UHCCP staff.

It is best to avoid reliance on family members for interpretation services, as trained medical interpreters are better able to convey concepts correctly, and do not compromise patient confidentiality.

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; 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 individuals with disabilities in
2.3 Cultural Competency

The communities that we jointly serve include a variety of cultures, races, religions, languages, and ethnic backgrounds. This can create barriers to receiving the care needed by TennCare members. In order to maximize the effectiveness of care, both providers and UHCCP must reach out to members in ways that are designed to recognize and respect each person as an individual. Information to assist providers in cultural awareness as well as continuing education opportunities is available on the U.S. Department of Health & Human Services Office of Minority Health website www.minorityhealth.hhs.gov.

The U.S. Department of Health and Human Services can recommend resources for use when LEP services are needed or providers cannot locate interpreters specializing in meeting needs of LEP clients. See: http://www.hhs.gov/ocr/civilrights/resources/providers/index.html#ocrres. In addition, the Language Line below is a recommended resource.

- Language Line 800-758-1638

Providers may also consider:

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

It is best to avoid reliance on family members for interpretation services, as trained medical interpreters are better able to convey concepts correctly, and do not compromise patient confidentiality. See: http://www.gpo.gov/fdsys/pkg/FR-2000-08-16/pdf/00-20938.pdf.

UHCCP does not reimburse for translation services offered to TennCare members in the provider’s office setting. According to Federal and state regulations of the Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) are to be provided by the entity who received the request for service. The Executive Order, signed August 11, 2000, by former President William Clinton, includes specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs. Charges for these services should not be billed to UHCCP and it is not permissible to charge a UHCCP member for these services.

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 an individual 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 individual. However, if available, the provider shall provide the individual with another form of an auxiliary aid or service that would achieve effective communication with the individual and not result in a fundamental alteration in the nature of the provider’s services or result in an undue financial and administrative burden.
3. **Provider Participation Requirements**

3.1 **Disclosure of Criminal Conviction, Ownership and Control Interest**

Prior to payment for any services rendered to TennCare members, the provider must have completed and filed disclosure information with UHCCP in accordance with requirements in 42 CFR, Part 455, Subpart B. This disclosure of criminal convictions related to the Medicare and Medicaid programs is required by CMS. These requirements hold that individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest. No claims will be paid without receipt of a complete and current disclosure.

You can use the same disclosure form for the State, UHCCP, and any other Managed Care Organizations within the state. The latest version of the form is available on [http://www.uhccommunityplan.com/health-professionals/tn/provider-forms.html](http://www.uhccommunityplan.com/health-professionals/tn/provider-forms.html).

3.2 **Tennessee Medicaid ID**

All providers must receive a Tennessee Medicaid ID prior to claims payment for TennCare members. Your office can file for a group/business number, and individual health care professionals working within the group also need an assignment. This ID is assigned by the Bureau of TennCare, and is available on the web. Some provider types are ineligible to receive Medicare IDs, but all providers will be assigned a Medicaid ID through this process. To apply for a Tennessee Medicaid ID, you may call TennCare at 800-852-2683. The website address for applications is: [http://www.tn.gov/tenncare/pro-forms.html](http://www.tn.gov/tenncare/pro-forms.html)

3.3 **National Provider Identifier (NPI)**

The National Provider Identifier (NPI) is required on all standard HIPAA transactions, including claim submission. Claims must be filed using standard formats and the NPI of the appropriate healthcare professionals, including, but not limited to, rendering, attending, and referring providers.

3.4 **Changes to Demographic Information**

It is important to notify us of any demographic changes 30 days prior to the change becoming effective. Some examples of these changes are practice location, telephone number, license changes, Tax Identification Number, or panel status regarding acceptance of new patients. You have two options for notifying UHCCP about changes to your physician, practice or facility demographics.

1. Complete and fax the Physician and Provider Demographic Change Submission Form to 855-263-9590. This form can also be found in the Forms Appendix of this Manual.

2. Complete and email the Physician and Provider Demographic Change Submission form to JDHPdemo@uhc.com. This form can also be found in the Forms Appendix of this Manual.

For HCBS providers, please see Chapter XX, Section M-1 for instructions on updating demographic information.
If terminating your participation, you must submit a termination notification to us in the time frames stated in the Provider Agreement. All notices must be in writing and delivered either personally or sent by certified mail with postage prepaid. If mailed, such notice shall be deemed to be delivered when deposited in the United States Mail Addressed to:

UnitedHealthcare
Attn: Network Management
10 Cadillac Dr., Suite 200
Brentwood, TN 37027

If services covered by the contract agreement are added or discontinued, the provider is responsible for notifying UHCCP prior to such discontinuation or addition. Written notice of discontinuation of previously available services must be submitted at least thirty (30) days prior to the discontinuation. UHCCP will review the changes requested to ensure adequacy of member access for service. If the need for additional service exists, the provider must comply with UHCCP credentialing requirements for that new service. A current Provider agreement will not automatically include a new location. Each request will be evaluated on an individual basis.

4. Health Insurance Portability and Accountability Act (HIPAA)

Privacy of medical information is important to all covered entities. New Federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way UHCCP operates; however, it will not prevent us from exchanging the information we need for treatment, payment and health care operations (TPO).

UHCCP will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information and UHCCP providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of UHCCP members available to each physician and/or health care professional treating UHCCP members and to UHCCP, its agents or representatives.

Privacy Regulations should not impact patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. The following offers examples of TPO, which include, but are not limited to:

Treatment – rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.

Payment – the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.

Health care operations – conducting quality assessment and improvement activities, underwriting, premium rating auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and further information regarding HIPAA requirements, please visit the U.S. Department of Health and Human Services website at: [http://www.hhs.gov/policies/index.html](http://www.hhs.gov/policies/index.html)

If you have any questions or concerns regarding privacy matters, you may contact the UHCCP at 800-690-1606.
4.1 Confidentiality

Personal and medical information regarding members of any plans administered by UHCCP is highly confidential. It is the responsibility of each employee of UHCCP and of independent contractors providing services to UHCCP or its subsidiaries, to protect all confidential information by adhering to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Gramm-Leach-Bliley Act of 1999 (GLBA) when appropriate, and established UHCCP Policy and Guidelines.

Employees of UHCCP and independent contractors providing services to UHCCP shall have access to confidential information only as minimally necessary to perform their functional responsibilities. Wrongful disclosure of confidential information will result in appropriate discipline and corrective action.

4.2 Uses and Disclosures of PHI

Protected Health Information (PHI) is information that relates to the past, present, or future physical or mental health or condition; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual. PHI is the health information itself and the information that would connect the person to their health information and/or health history.

UHCCP uses PHI, collected from members and subscribers, for purposes of treatment, payment or health care operations and health oversight and its related functions. Disclosure of PHI is not used for marketing purposes or any other purpose outside of payment and health care operations, except when required for judicial and administrative proceedings such as complying with subpoenas.

4.3 Use of Release of Information

A TennCare approved UnitedHealth Group Authorization to Release Information form is used when a member would like to allow someone other than himself/herself oral and/or written access to his/her information. However, as a condition of participation in the TennCare program, all TennCare members have granted access to their information to their assigned Managed Care Organization (MCO), the State of Tennessee, and appropriate Federal oversight bodies. Members should call Customer Service at 800-690-1606 for assistance with the UnitedHealth Group Authorization to Release Information form.

4.4 Identification and Authentication

When someone other than the member requests access to health care information, UHCCP utilizes a validation process for identification and authentication to ensure the person is who he/she says he/she is before providing member information to this person.

4.5 Internal Protection of Oral, Written and Electronic PHI

UHCCP has policies and procedures to ensure members' information is safeguarded.

- Records containing PHI may be viewed only by appropriate authorized personnel and auditors.
- Hard copy records containing PHI are secured under lock and key.
- Electronic copies of records containing PHI are maintained in a protected file.
- Once the business purpose for which the data was gathered and all reasonable future use is completed, records containing PHI are shredded or appropriately destroyed.
- Privacy training for staff
5.1 Fraud and Abuse (TennCare)

Any unethical, unlawful or otherwise inappropriate activity by a UHCCP employee which comes to the attention of a provider should be reported to UHCCP at 800-690-1606. UHCCP's Anti-Fraud, Waste and Abuse Program (Anti FWA) is an important component of the Compliance Program. This program focuses on proactive prevention, detection, and investigation of potentially fraudulent and abusive acts committed by providers and UHCCP members. A toll-free Fraud and Abuse Hotline (800-690-1606) has been set up to facilitate the reporting process of any questionable incidents involving UHCCP members or providers.

Through the Anti-Fraud, Waste, and Abuse Program, UHCCP’s mission is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money it has paid for fraudulent, wasteful or abusive claims. UHCCP will also appropriately refer suspected fraud, waste and abuse (FWA) cases to law enforcement, regulatory, and administrative agencies pursuant to state and Federal law. UHCCP seeks to protect the ethical and fiscal integrity of the company and its employees, members, providers, government programs, and the public, as well as safeguard the health and well-being of its members.

UHCCP is committed to vigilant compliance with its Anti-FWA Program and all applicable Federal and state regulatory requirements governing its Anti-FWA Program. UHCCP recognizes that state and Federal health plans are particularly vulnerable to fraud, waste and abuse and strives to tailor its efforts to the unique needs of its members and Medicaid, Medicare and other government partners.

All suspected instances of FWA in any way and in any form are thoroughly investigated. In appropriate cases, the matters are reported to law enforcement and/or regulatory authorities, in accordance with Federal and state requirements. UHCCP cooperates with law enforcement and regulatory agencies in the investigation or prevention of FWA.

An important aspect of the Compliance Program is assessing high-risk areas of UHCCP operations and implementing periodic reviews and audits to ensure compliance with law, regulations, and contracts. When informed of potentially irregular, inappropriate or potentially fraudulent practices within UHCCP or by our providers, UHCCP will conduct an appropriate investigation. Providers are expected to cooperate with the company and government authorities in any such inquiry, both by providing access to pertinent records (as required by the Participating Provider Agreement) and access to provider office staff. If activity in violation of law or regulation is established, appropriate governmental authorities will be advised. If a provider becomes the subject of a governmental inquiry or investigation, or a government agency requests or subpoenas documents relating to the provider’s operations (other than a routine request for documentation from a regulatory agency), the provider must advise the UHCCP of the details of this and of the factual situation which gave rise to the inquiry.

5.2 Deficit Reduction Act

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are aimed at reducing fraud within the health care programs funded by the Federal government. Section 6032 of the Deficit Reduction Act contains information regarding the Federal False Claims Acts and whistleblower protection. In addition, there is a Tennessee Medicaid False Claims Act which contains the same whistleblower protections.

Under Section 6032 of the DRA, every entity that receives at least five million dollars ($5,000,000) in Medicaid payments annually must establish written policies for all employees of the entity, and for all employees of any contractor or agent of the entity, providing detailed information about false claims, false statements and whistleblower protections under applicable Federal and state fraud and abuse laws.
Due to the fact that UHCCP receives five million dollars ($5,000,000) in Medicaid payments annually and is subject to this provision, as a contracted provider with UHCCP, you and your staff are subject to this provision. This means that you must educate your employees on an annual basis to ensure compliance with these requirements. Records of the training should be maintained in the event of an audit. There are resources available on the Provider Website regarding these requirements including the UnitedHealth Group policy, titled “Integrity of Claims, Reports and Representations to Government Entities” and the TN State Medicaid False Claims Act. This policy details our commitment to compliance with the Federal and state false claims acts, provides a detailed description of these acts and of the mechanisms in place within our organization to detect and prevent fraud, waste and abuse, as well as the rights of employees to be protected as whistleblowers. The policy can be found at [http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/all-dra-language.pdf](http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/all-dra-language.pdf)

You may also reach out to your Provider Advocate for additional guidance.

**Federal False Claims Act**

- The Federal False Claims Act prohibits knowingly submitting (or causing to be submitted) to the Federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by a state Medicaid program, the Federal government or its agents, such as a carrier or other claims processor.
- Civil penalties can be imposed on any person or entity that violates the Federal False Claims Act, including monetary penalties of $5,500 to $11,000 as well as damages of up to three (3) times the Federal government’s damages for each false claim.

**Federal Fraud Civil Remedies**

- The Program Fraud Civil Remedies Act of 1986 also allows the government to impose civil penalties against any person who makes, submits or presents false, fictitious or fraudulent claims or written statements to designated Federal agencies, including the U.S. Department of Health and Human Services, which is the Federal agency that oversees the Medicare and Medicaid Programs.

**State False Claims Acts**

- Tennessee also has enacted broad false claims laws modeled after the Federal False Claims Act or have legislation pending that is similar to the Federal False Claims Act. Other states have enacted false claims laws that have provisions limited to health care fraud.

**Whistleblower and Whistleblower Protections**

- The Federal False Claims Act and some state false claims acts permit private citizens with knowledge of fraud against the U.S. Government or state government to file suit on behalf of the government against the person or business that committed the fraud.
- Individuals who file such suits are known as a "qui tam" plaintiff or "whistleblower." The Federal False Claims Act and some state false claims acts also prohibit retaliation against an employee for investigating, filing or participating in a whistleblower action.

**Reporting**

Anyone suspecting violations of the fraud, waste and abuse requirements can report such activity to one of the following entities:
• The Office of Inspector General website is at: www.oig.hhs.gov
• Report TennCare fraud & abuse to the Office of Inspector General at www.tn.gov/tnoig/ReportTennCareFraud.html or call 800-433-3982
• Report fraud and abuse to UHCCP at 800-690-1606.

5.3 Background Check Requirements

Providers will need to perform background checks as required by the state licensing agency on employees which includes a criminal background check, or, as an alternative, a background check from a licensed private investigation, company, verification that the person’s name does not appear on the State abuse registry, verification that the person’s name does not appear on the state and national sexual offender registries and licensure verification. Nursing facilities will continue to perform background checks as they have in the past, in accordance with Health Facilities survey and CMS survey requirements.

5.4 Exclusion Database Verification


Ineligible Persons – “Ineligible Persons” shall mean any individual or entity who: (a) is, as of the date such Exclusion Lists are accessed by Provider, excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (b) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible.

As a contracted provider, you are required to screen your employees and contractors (“screened persons”) against the Federal Exclusions Lists initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal or state health care programs or with an entity that employs or contracts with such an individual or entity. You must immediately report to UHCCP any exclusion information you discover to your appropriate Provider Advocate or by calling 800-690-1606. Civil monetary penalties may be imposed against entities who employ or enter into contracts with excluded individuals or entities to provide items or services to TennCare members.

If you determine that a screened person has become an ineligible person, you must take appropriate action to remove such screened person from responsibility for, or involvement with, your professional or business operations related to the Federal health care programs and shall remove such screened person from any position for which the screened person’s compensation or the items or services furnished, ordered, or prescribed by the screened person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds at least until such time as the screened person is reinstated into participation in the Federal health care programs.

If you determine that a screened person is an ineligible person charged with a criminal offense that falls within the ambit of 42 U.S.C. §§ 1320a-7(a) or is proposed for exclusion during the screened person’s employment or contract term, you must take all appropriate actions to ensure that the responsibilities of that screened person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal health care program.
### A. Verification of Eligibility

#### 1. Eligibility Categories

**1.1 TennCare Medicaid**

As provided in state rules and regulations, TennCare Medicaid covers all Medicaid mandatory eligibility groups as well as various optional categorically needy and medically needy groups, including children, pregnant women, the aged and individuals with disabilities.

Additional detail about eligibility criteria for covered groups is provided on the State's web site in the TennCare Rules and the Department of Human Services Rules at:


**1.2 TennCare Standard**

TennCare Standard includes the Standard Spend Down (SSD) population, the CHOICES 217-Like Home and Community Based Services Group, and an expanded population of children.

**1.3 Presumptive Eligibility for Breast/Cervical Cancer Group**

Women who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, who are under age 65, and who have been determined by the County Department of Health to need treatment for breast or cervical cancer are eligible to enroll in TennCare Medicaid. This Presumptive Eligibility due to breast or cervical cancer is good for 45 days. In order to continue with TennCare eligibility, the presumptively eligible member must call Tennessee Health Connection at 1-855-259-0701. The eligibility date will be the day the Department of Health approved the member for the presumptive eligibility status.

**1.4 Presumptive Eligibility for Maternity**

See Section XIII - OB Services for information regarding presumptive eligibility for pregnant women.

<table>
<thead>
<tr>
<th>TennCare Medicaid Membership Category</th>
<th>Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child under age 21, who does NOT have Medicare</td>
<td>A</td>
</tr>
<tr>
<td>A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who does not get long-term care that TennCare pays for</td>
<td>B</td>
</tr>
<tr>
<td>A TennCare Standard adult age 21 and older</td>
<td>C</td>
</tr>
<tr>
<td>A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who is Medically Needy (Spend Down)</td>
<td>D</td>
</tr>
</tbody>
</table>
2. How to Verify Eligibility

UHCCP recommends providers conduct an eligibility search on all patients to identify any existence of TennCare coverage prior to rendering services. TennCare eligibility can be verified in any of the following ways:

- Review the customers eligibility at UHCCommunityPlan.com
- Calling the UHCCP Enhanced Voice Portal at 800-690-1606
- Accessing the online eligibility verification link on the state Web site at http://www.tn.gov/tenncare/pro-verifyeligi.html
- Calling the Bureau of TennCare at 800-852-2683.
- Presumptively eligible women will receive a letter completed by a local county health department. These letters must be accepted as verification of eligibility. Please retain a copy for your records.

### TennCare Medicaid Membership Category

<table>
<thead>
<tr>
<th>TennCare Medicaid Membership Category</th>
<th>Benefit Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>A TennCare Medicaid adult age 21 and older who does NOT have Medicare and who gets long-term care that TennCare pays for</td>
<td>E</td>
</tr>
<tr>
<td>A TennCare Medicaid adult age 21 and older who does NOT get long-term care that TennCare pays for, and who has Medicare</td>
<td>F</td>
</tr>
<tr>
<td>A TennCare Medicaid adult age 21 and older who gets long-term care that TennCare pays for, and who has Medicare</td>
<td>G</td>
</tr>
<tr>
<td>A child under age 21 who has Medicare</td>
<td>H</td>
</tr>
<tr>
<td>Medicaid members of all ages who are receiving Medicaid-reimbursed care in a nursing facility.</td>
<td>Choices Group 1</td>
</tr>
<tr>
<td>Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare as SSI recipients or as members of the of the CHOICES 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TennCare has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.</td>
<td>Choices Group 2</td>
</tr>
<tr>
<td>Interim Group 3 (open for new enrollment only between July 1, 2012, through June 30, 2015 Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligibles or as members of MOE Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.</td>
<td>CHOICES Interim Group 3</td>
</tr>
<tr>
<td>Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.</td>
<td>CHOICES Group 3</td>
</tr>
</tbody>
</table>
Eligibility information for undocumented residents should be verified by calling the UHCCP Customer Service at 800-690-1606. Medical emergency services (inpatient and outpatient), along with maternity services are the only benefits available to the undocumented resident population. Maternity benefits consist of labor and delivery services only.

Disclaimer: Eligibility & benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered and benefit plan terms and conditions.

**B. Member ID Card**

Each UHCCP member receives a Member ID Card for the purposes of identifying eligibility, the Primary Care Practitioner (PCP), effective date and any copays that might be necessary. Each time the member changes the PCP, a new Member ID Card is issued.

The UHCCP TennCare ID card provides the following information:

- Member Name
- Member ID Number
- Effective date
- Assigned Primary Care Practitioner
- Member's liability (if applicable)
- Member's Date of Birth
- TennCare eligibility classification
- Benefit level; and
- Copayment (if applicable)

If a TennCare member is unable to present the member ID card at the time of service, providers can verify eligibility as specified above.
A. TennCare Member Rights and Responsibilities

TennCare members have specific rights and responsibilities related to their health care. It is important to incorporate these rights and responsibilities into all services and to encourage open communication if a member ever has questions. Each member receives the Member Rights and Responsibilities within the Member Handbook; however, a copy has been included below so that you may understand them as well.

Your Rights and Responsibilities as a TennCare and UnitedHealthcare Community Plan Member

You have the right to:

• Be treated with respect and in a dignified way. You have a right to privacy and to have your medical and financial information treated with privacy.

• Ask for and get information about UnitedHealthcare Community Plan, its policies, its services, its caregivers, and members’ rights and duties.

• Ask for and get information about how UnitedHealthcare Community Plan pays its providers, including any kind of bonus for care based on cost or quality.

• Ask for and get information about your medical records as the Federal and state laws say. You can see your medical records, get copies of your medical records, and ask to correct your medical records if they are wrong.

• Get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, disability, or any other classification protected under the applicable federal and state civil rights laws. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from UnitedHealthcare Community Plan, providers, or TennCare.

• Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience or revenge.

• Make appeals or complaints about UnitedHealthcare Community Plan or your care. Part 4 of this handbook tells you how.

• Make suggestions about your rights and responsibilities or how UnitedHealthcare Community Plan works.

• Choose a PCP in the UnitedHealthcare Community Plan network. You can turn down care from certain providers.

• Get medically necessary care that is right for you, when you need it. This includes getting emergency services, 24 hours a day, 7 days a week.

• Be told in an easy-to-understand way about your care and all of the different kinds of treatment that could work for you, no matter what they cost or even if they aren’t covered.

• Help to make decisions about your health care.

• Make a living will or advance care plan and be told about Advance Medical Directives.
• Change health plans. If you are new to TennCare, you can change health plans once during the 45 days after you get TennCare. After that, you can ask to change health plans through an appeal process. There are certain reasons why you can change health plans. Part 4 of this handbook tells you more about changing health plans.

• Ask TennCare and UnitedHealthcare Community Plan to look again at any mistake you think they make about getting on TennCare or keeping your TennCare or about getting your health care.

• End your TennCare at any time.

• Exercise any of these rights without changing the way UnitedHealthcare Community Plan or its providers treat you.

**Your rights to stay with UnitedHealthcare Community Plan**

**As a UnitedHealthcare Community Plan member, you cannot be moved from UnitedHealthcare Community Plan just because:**

• Your health gets worse.

• You already have a medical problem. This is called a pre-existing condition.

• Your medical treatment is expensive.

• Of how you use your services.

• You have a mental health condition.

• Your special needs make you act in an uncooperative or disruptive way.

Here are the only reasons you can be moved from UnitedHealthcare Community Plan:

• If you change health plans.

• If you move out of the UnitedHealthcare Community Plan area.

• If you let someone else use your ID cards, or if you use your TennCare to get medicines to sell.

• If you end your TennCare or your TennCare ends for other reasons.

• If you don’t renew your TennCare when it is time, or if you don’t give TennCare information they ask for when it is time to renew.

• If you don’t let TennCare and UnitedHealthcare Community Plan know that you moved, and they can’t find you.

• If you lie to get or keep your TennCare.

• Upon your death.

As a TennCare and UnitedHealthcare Community Plan member, you also have the responsibility to:

• Understand the information in your Member Handbook and other papers that we send you.
• Show your UnitedHealthcare Community Plan ID card whenever you get health care. If you have other insurance, you must show that card too.

• Go to your PCP for all your medical care unless:
  – Your PCP sends you to a specialist for care. You must get a referral from your PCP to go to a specialist.
  – You are pregnant or getting well-woman check ups.
  – It is an emergency.

• Use providers who are in the UnitedHealthcare Community Plan provider network. But, you can see anyone if it is an emergency. And, you can see anyone who has been approved with a referral.

• Let your PCP know when you have had to go to the Emergency Room. You (or someone for you) need to let your PCP know within 24 hours of when you got care at the ER.

• Give information to the UnitedHealthcare Community Plan and to your health care providers so that they can care for you.

• Follow instructions and rules that are in the handbook about your coverage and benefits. You must also follow instructions and rules from the people who are giving you health care.

• Help to make the decisions about your health care.

• Work with your PCP so that you understand your health problems. You must also work with your PCP to come up with a treatment plan that you both say will help you.

• Treat your health care giver with respect and dignity.

• Keep health care appointments and call the office to cancel if you can’t keep your appointment.

• Be the only one who uses your UnitedHealthcare Community Plan ID card and let us know if it is lost or stolen.

• Tell TennCare of any changes like:
  – If you or a family member change your name, address, or phone number.
  – If you have a change in family size.
  – If you or a family member get a job, lose your job, or change jobs.
  – If you or a family member has other health insurance or can get other health insurance.

• Pay any copays you need to pay.

• Let UnitedHealthcare Community Plan know if you have another insurance company that should pay your medical care. The other insurance company could be insurance like auto, home, or worker’s compensation.
**B. Member Access to Care**

UHCCP has established standards for the access and availability of network primary care, designated specialty care practitioners including behavioral health, CHOICES nursing facilities, home and community based services (HCBS), and provider services, as necessary to meet the health care needs of the member population. This includes a focus on Limited English Proficiency groups identified by TennCare that represent five percent (5%) of the TennCare population or one-thousand members, whichever is less.

UHCCP members expect, and should receive, reasonable and timely access to health care from participating practitioners irrespective of physical, mental, language, or cultural barriers. UHCCP’s goal is to select and retain practitioners and providers to meet the medical, long term services and supports, and behavioral health care needs of TennCare members. These standards allow for evaluation of practitioners’ performance in the area concerning accessibility of appointments and scheduling times. These standards allow for evaluation of UHCCP’s performance in the area concerning an adequate availability of practicing providers.

1. **Accessibility Guidelines**
   
   1.1 Access to Care

   Accessibility guidelines are established to ensure that members are provided with access to timely, urgent, routine, and consult appointments, telephone procedures, and after hours or emergent care.

   Each participating provider will provide or will arrange to provide all necessary services to members on a 24 hour per day, 7 day per week basis. Access will be provided after hours through on-call coverage.

   • **Preventive:** This category consists of covered services for initial and periodic evaluations, family planning services, prenatal care, laboratory services and immunizations in accordance with TennCare rules and regulations. Patients are normally free of symptoms or they have no acute symptoms.

   • **Routine:** This category consists of non-urgent, non-emergent, medical or behavioral health care such as screenings, immunizations, or health assessments.

   • **Urgent:** This category consists of covered services for an illness or injury manifesting itself by acute symptoms that are of lesser severity than emergent but requires care within 24-48 hours or covered services for medical care or treatment for an illness or injury that could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function, based on a prudent layperson’s judgment, or in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

   • **Emergency:** A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part.
1.2 Appointment Scheduling Guidelines

- Preventive physical exam appointments on patients with no acute problems should be scheduled within three (3) weeks.
  - Well childcare appointments within three (3) weeks
  - General medical exams (including pelvic exams with PAP smears) should be scheduled within three (3) weeks
  - For women who are past their first trimester of pregnancy on the day they are determined to be eligible, a first prenatal care appointment shall occur within fifteen (15) calendar days of the day they are determined to be eligible.
  - Preventive Optometry care within three (3) weeks and 48 hours for urgent care
  - General Optometry Services not to exceed three (3) weeks for regular appointments and 48 hours for urgent care
  - Lab and X-ray appointments within three (3) weeks for regular appointments and 48 hours for urgent care
- Appointments for urgent complaints that can be handled in the office should be seen within 48 hours. Patient phone calls for urgent complaints should result in either an appointment to be seen within 48 hours or telephone follow-up with referral for urgent care.
- Emergency services can be obtained at the nearest available facility, regardless of the network status.
- Specialty Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care.
- Routine care (non-urgent, non-emergent, symptomatic conditions) appointments with PCP should be scheduled within 3 weeks and 48 hours for urgent care.
- Access will be provided after hours through on-call coverage.

1.3 Waiting Time Guidelines

- A practitioner or his/her designee should be available 24 hours a day/seven (7) days a week
- After hours calls to the answering service for urgent problems are to be returned within 15 minutes or as soon as possible.
- Urgent phone calls to the practitioner during regular office hours are to be returned the same day by the practitioner or designee. The Practitioner office staff should set an expectation with the caller as to when the call will be returned.
- Non-urgent phone calls to the practitioner during regular office hours are to be returned by the practitioner or his staff designee as soon as possible.
• Patients with scheduled appointments are to be seen by the practitioner within forty five (45) minutes of their scheduled appointments.

• Patients scheduled for procedures (lab, x-rays) are to be seen within forty five (45) minutes of their scheduled procedure.

• All emergency care is immediate, at the nearest facility available, regardless of contract. Waiting times shall not exceed 45 minutes.

1.4 Availability
Availability guidelines are established to meet the health care needs of the member population or demographically significant sub-populations.

Availability Standards are:
• PCP and/or Extender
  – Rural: Not to exceed 30 miles (one way) or 30 minutes
  – Urban: Not to exceed 20 miles (one way) or 30 minutes
  – Patient Load: 2,500 or less for physician; one-half this for a physician extender

• Specialty care:
  – Travel distance does not exceed 60 miles for at least 75% of non-dual members and
  – Travel distance does not exceed 90 miles for ALL non-dual members

• Hospital: Not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented.

• General Optometry Services: Not to exceed 30 minutes, except in rural areas where community standards and documentation shall apply.

• Lab & X-ray: Not to exceed 30 minutes

• Pharmacy Services: Not to exceed 30 minutes

• Long Term Services and Supports: Transport distance to licensed Adult Day Care providers will be the usual and customary not to exceed 20 miles for TennCare members in urban areas, not to exceed 30 miles for TennCare members in suburban areas and not to exceed 60 miles for TennCare members in rural areas except where community standards and documentation shall apply.
## 2. Behavioral Health Access and Availability Standards

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Geographic Access Requirement</th>
<th>Maximum Time for Admission/Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services</td>
<td>Travel Distance does not exceed 90 miles for at least 90% of members.</td>
<td>4 hours (emergency involuntary)/24 hours (involuntary)/24 hours (voluntary)</td>
</tr>
<tr>
<td>24 Hour Psychiatric Residential Treatment</td>
<td>UHCCP shall contract with at least one (1) provider of this service in each Grand Region for ADULT members. Travel distance does not exceed 60 miles for at least 75% of CHILD members and does not exceed 90 miles for at least 90% of CHILD members.</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Outpatient Non-MD Services</td>
<td>Travel distance does not exceed 30 miles for ALL members</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td>Intensive Outpatient (may include Day Treatment (adult), Intensive Day Treatment (Children &amp; Adolescent) or Partial Hospitalization)</td>
<td>Travel distance does not exceed 90 miles for at least 90% of members.</td>
<td>Within 10 business days; if urgent, within 48 hours</td>
</tr>
<tr>
<td>Inpatient Facility Services (Substance Abuse)</td>
<td>Travel distance does not exceed 90 miles for at least 90% of members.</td>
<td>Within 2 calendar days; for detoxification - within 4 hours in an emergency and 24 hours for non-emergency</td>
</tr>
<tr>
<td>24 Hour Residential Treatment Services (Substance Abuse)</td>
<td>UHCCP shall contract with at least one (1) provider of this service in each Grand Region for ADULT members. UHCCP shall contract with at least one (1) provider of this service in each Grand Region for CHILD members.</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Outpatient Treatment Services (Substance Abuse)</td>
<td>Travel distance does not exceed 30 miles for ALL members</td>
<td>Within 10 business days; for detoxification – within 24 hours</td>
</tr>
<tr>
<td>Mental Health Case Management</td>
<td>Not subject to geographic access standards</td>
<td>Within 7 calendar days</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (may include Supported Employment, Illness Management &amp; Recovery, or Peer Support)</td>
<td>Not subject to geographic access standards</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>Not subject to geographic access standards</td>
<td>Within 30 calendar days</td>
</tr>
<tr>
<td>Crisis Services (Mobile)</td>
<td>Not subject to geographic access standards</td>
<td>Face-to-face contact within 1 hour for emergency situations and 4 hours for urgent situations</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>Not subject to geographic access standards</td>
<td>Within 4 hours of referral</td>
</tr>
</tbody>
</table>
*According to NCQA standards, all routine behavioral health office visits should be accessible within ten (10) business days. UnitedHealthcare Community Plan is required to adhere to the most stringent access and availability standards.

**C. Member Liability**

1. **Billing a TennCare Member**

Providers may not bill TennCare members for covered services other than their allowed cost-sharing responsibilities. There are Tennessee State and Federal prohibitions regarding billing TennCare members. The Tennessee prohibition can be found in the Bureau of TennCare Rules in Sections 1200-13-13-.08 and 1200-13-14-.08. The Federal law prohibition is found at 42 U.S.C.A. § 1395cc and 42 U.S.C.A. § 1396a(p).

1.1 **When a Provider CAN Bill TennCare Member**

The TennCare rules state that providers may seek payment from a TennCare member only under the following circumstances:

(a) If the services are not covered by the TennCare program and, prior to providing the services, the provider informed the member that the services were not covered. If the member still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service.

(b) If the member’s TennCare eligibility is pending at the time services are provided and if the provider informs the person that TennCare assignment will not be accepted whether or not eligibility is established retroactively. Providers may bill such persons at the provider’s usual and customary rate for the services rendered.

**IMPORTANT NOTICE REGARDING 1.a AND 1.b ABOVE:** Regardless of any understanding worked out between the provider and the member about private payment, once the provider bills UHCCP 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.

(c) If the member’s TennCare eligibility is pending at the time services are provided. However, if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established, all monies collected for TennCare covered services rendered during the period of time when the member was eligible for TennCare, except any applicable cost sharing amounts, must be refunded when a claim is submitted to UHCCP.

**IMPORTANT NOTICE REGARDING 1.c ABOVE:** All money collected, except applicable cost sharing amounts, must be refunded immediately and cannot be held conditionally upon payment of the claim by UHCCP.

(d) If the services are not covered because they are in excess of a member’s benefit limit and one of the following circumstances applies:

1. The provider determines effective on the date of service that the member has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the member that the service is not covered and the service will not be paid for by TennCare. The source of the provider’s information must be a database listed on the TennCare website as approved by TennCare on the date of the provider’s inquiry.
2. The provider has information in his/her own records to support the fact that the member has reached his/her benefit limit for the particular service being requested and, prior to providing the service, informs the member that the service is not covered and will not be paid for by TennCare. This information may include:

- A previous written denial of a claim on the basis that the service was in excess of the member’s benefit limit for a service within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect;

- That the provider had previously examined the database referenced in section (d)1 above and determined that the member had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect;

- That the provider had personally provided services to the member in excess of his/her benefit limit within the same benefit category as the service being requested, if the time period applicable to that benefit limit is still in effect; or

- UHCCP has provided confirmation to the provider that the member has reached his/her benefit limit for the applicable service.

3. The provider submits a claim for service to UHCCP and receives a written denial of that claim on the basis that the service exceeds the member's benefit limit. Thereafter, within the remainder of the period applicable to that benefit limit, the provider may continue to bill the member for services within that same exhausted benefit category without having to submit, for repeated UHCCP denial, claims for those subsequent services.

4. The provider had previously taken the steps in parts 1, 2, or 3 above and determined that the member had reached his/her benefit limit for the particular service being requested, if the time period applicable to that benefit limit is still in effect, and informs the member, prior to providing the service, that the service is not covered and will not be paid for by UHCCP.

(e) If the services are covered only with prior authorization and prior authorization has been requested but denied, or is requested and a specified lesser level of care is approved, and the provider has given prior notice to the member that the services are not covered, the member may elect to receive those services for which prior authorization has been denied or which exceed the authorized level of care and be billed by the provider for such services.

1.2 When a Provider CANNOT Bill a TennCare Member

Providers may not seek payment from a TennCare member under the following conditions:

a) The provider knew or should have known about the patient’s TennCare eligibility or pending eligibility prior to providing services.

b) The claim(s) submitted to UHCCP for payment was/were denied due to provider billing error or a claim processing error.

c) The provider accepted TennCare assignment on a claim and it is determined that another payer paid an amount equal to or greater than the TennCare allowable amount.
d) The provider failed to comply with TennCare policies and procedures or provided a service which lacks medical necessity or justification.

e) The provider failed to submit or resubmit claims for payment within the time periods required by UHCCP or TennCare.

f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services. Even if the member presents another form of insurance, the provider must determine whether the patient is covered under TennCare.

g) The provider failed to inform the member prior to providing a service not covered by TennCare that the service was not covered and the member may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement. Notwithstanding this exemption, providers shall remain obligated to provide notice to members who have exceeded benefit limits in accordance with Rule 1200-13-13-.11.

h) The member failed to keep a scheduled appointment(s).

i) The provider is a TennCare provider, as defined by the rules, but is not participating with UHCCP and is seeking to bill the member as though the provider were a Non-TennCare provider, as defined by the Rules.

1.3 Notice for Non-participating Providers

Any non-participating provider who provides TennCare covered non-emergency services to TennCare members without authorization from UHCCP does so at his/her own risk. A non-participating provider can only bill a TennCare member in instances as described above in Section E-1.1 (a), (d) and (e).


2. Member Cost Sharing Responsibilities

A contracted provider shall collect from the member any applicable TennCare co-payments or CHOICES patient liability. Reasonable efforts to collect should include, but are not limited to, referral to a collection agency and where appropriate, court action. Documentation of the collection efforts must be maintained and made available to UHCCP upon request. For a detailed co-payment schedule, please refer to the ATTACHMENT II COST SHARING SCHEDULE in the TennCare Contractor Risk Agreement at http://www.tn.gov/tenncare/pro-mcos.html.

2.1 Notice to Cease Billing

Federal and Tennessee law prohibit providers participating in the TennCare program from billing or attempting to collect payment from TennCare members for TennCare-authorized and/or Covered Services other than applicable copayments permitted by TennCare Rules and Regulations 1200-13-12-.08, 1200-13-13-.08 (Medicaid) or 1200-13-14-.08 (Standard). Additional guidance can be found in the TennCare Policy Manual located on the TennCare Bureau website at http://tn.gov/tenncare/forms/pro08001.pdf. As directed by the Bureau of TennCare, UHCCP, as a TennCare Managed Care Organization, shall ensure that the participating provider ceases all activity to bill a UHCCP member by issuing a “Cease to Bill Notice” to the provider.
D. Member Appeals

1. Grier Consent Decree

The Grier Consent Decree (“Grier”) specifies TennCare member rights in regards to any adverse action to deny, reduce, terminate, delay or suspend health care services. It also specifies the notification requirements in order to alert the member of his/her appeal rights. It is very important that you understand the Grier Consent Decree and all processes around member appeals, requesting prior authorizations and maintaining medical records.

In order to help ensure compliance, the Bureau of TennCare formed the TennCare Solutions Unit (TSU) to provide oversight of the TennCare appeals process following the Federal court decision in Grier v. Wadley.

Responsibilities of TSU include:

• Answering member questions about their appeal rights.

• Initiating appeals at the member’s request by phone, fax, or mail.

• Processing the intake and distribution of TennCare appeals to the managed care organizations.

• Determining if the response to the member meets the Grier requirements.

• Determining if the appeal is resolved (closed) or forwarding it on to the Office of General Counsel for further review.

2. Member Appeals

TennCare members have the right to appeal any adverse actions taken by UHCCP. An adverse action is anything that denies, reduces, terminates, delays, or suspends a TennCare covered service, as well as any acts or omission which impair the quality, timeliness, or availability of TennCare covered services. TennCare members also have the right to appeal any provider initiated reduction, termination, or suspension of services. The appeal can be verbal or in writing, and can be made by the member or anyone else acting upon the member’s behalf. Members also have the right to make a complaint about any action by UHCCP or a provider which does not involve an adverse action. Healthcare providers play an integral role in the appeal process for TennCare members. This includes a provider acting on the member’s behalf with written consent, and providing medical records and certification of the emergent nature of appeals as appropriate. The TennCare program requires that providers comply with the appeal process, including:

• Assisting members by providing appeal forms and contact information including the appropriate address for submitting appeals for state level review. A copy of the appeals form has been included in the Forms Appendix.

• Seeking prior authorization in advance, when the provider feels that he/she cannot order a drug on the TennCare Preferred Drug List, as well as taking the initiative to seek prior authorization or change or cancel the prescription when contacted by a member or pharmacy regarding denial of a pharmacy service due to system edits (i.e., therapeutic duplication, etc.)

• Providing written certification when appropriate to support whether a member’s appeal is an emergency, (1) upon request by a member prior to filing an appeal; or (2) upon reconsideration of an appeal by UHCCP when requested by TennCare.

• Providing medical records as needed within TennCare Appeal timeframes, as communicated by UHCCP at the time of appeal.
• Displaying notices of TennCare member’s right to appeal adverse action affecting services in public areas of their facility(s) in accordance with TennCare Rules, subsequent amendments, or any and all Court Orders. A copy of the Notice of Appeal Rights poster has been included in the Forms Appendix. UHCCP shall ensure 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. UHCCP does not prohibit or discourage anyone from testifying on behalf of a member.

3. Notice of Appeal Rights

Both you and UHCCP are required to ensure members are educated about their appeal rights. Members receive notice of their right to appeal in their Member Handbook. In addition, your office must post a notice of these appeal rights as well. A copy of the Notice of Appeal Rights poster is included in the Forms Appendix. UHCCP must also provide the notice of appeal rights to members in the following circumstances:

• When any adverse action is taken by UHCCP to deny, reduce, suspend or terminate medical assistance
• When any action is taken that can reasonably be anticipated to delay or disrupt access to medical assistance including:
  – Change in PCP
  – Pharmacy lock-in
  – Termination of provider’s contract
  – Inability to provide an adequate provider network
• When any adverse action is initiated by UHCCP to reduce, terminate or suspend inpatient hospital care services.
• When a member has been prescribed a covered service on an on-going basis or with no specific ending date and the service is subject to a prior authorization requirement.
• When a provider has initiated reduction, termination, or suspension of:
  – 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.
  – Any behavioral health service for a TennCare Priority Enrollee;
  – Any inpatient psychiatric 24-hour or residential service; or
  – Home health services

In accordance with TennCare Rules 1200-13-13-.11, written notice of any provider initiated reduction, termination or suspension of services must be provided to an enrollee at least two (2) business days in advance of the proposed action. To ensure compliance with this written notice requirement, TennCare providers must promptly submit a Provider Initiated Notice (PIN) to UHCCP for any provider initiated reduction, termination or suspension of services. Additionally, UHCCP requires providers to submit a PIN for any provider initiated service delay. TennCare providers are required to adhere to the PIN guidelines outlined in the UHCCP PIN Guide. An electronic copy of the UHCCP PIN Guide is located in the Forms Appendix and the UHCCP provider website: http://www.uhccommunityplan.com/health-professionals/TN/provider-information.
4. Appeal Types and Timeframes

There are (2) two specific types of appeals – standard and expedited.

- **Standard** – A verbal or written request for reconsideration of an adverse action where the nature of the member’s condition and the urgency of his/her need do not necessitate expedited handling. It is also referred to as a non-urgent appeal. This type of appeal is further categorized as pre-service and post-service appeals.
  
  - Pre-Service: An appeal related to a service that has not yet been received by a member.
  
  - Post-Service: An appeal of a service that has already been received by a member.

- **Expedited** – An urgent appeal accepted in cases where the application of non-urgent appeal timelines could seriously jeopardize the member’s life, health or ability to regain maximum functioning, or in the opinion of the treating clinician the care requested is urgent or if not provided would cause the member severe harm.

Appeals must be filed within the following timeframes:

- If an adverse action letter was issued to the member - 30 calendar days from receipt of the adverse action letter.

- If an adverse action letter was not issued to the member - 30 calendar days from the date the Member becomes aware of the adverse action.

Appeals must be reviewed and the resolution communicated with the following timeframes:

- Standard – 14 days

- Expedited – 5 days

5. Medical Records

You can speed the review of any medical necessity appeal your office submits on behalf of a member by including medical records with the appeal. If the member appeals directly, we will contact you for copies of the record. Please forward any medical records requested as quickly as possible, due to the required timeframes specified in the section above (see Chapter IV, Section D-4). No release form is needed, as the TennCare member has agreed to release of medical records as a condition of their participation in the TennCare program. (PLEASE NOTE - For expedited appeals, if two (2) attempts are made by the UHCCP Appeals staff to request medical records and you do not respond with the necessary documentation, the UHCCP Appeals staff may request additional review time (up to 9 additional days) from the TennCare Solutions Unit.

6. Sample Member Adverse Action Letter

As stated above, the Grier Consent Decree details all notice requirements for adverse actions. A sample adverse action letter has been included on the following page.
Member Name  
Address  
Address 2  
City, State, Zip  

UnitedHealthcare Community Plan won't pay for this care for you:

- <amount and type of service denied>.

The doctor who asked for this care is <prescriber name>.

To find out why we won’t pay, keep reading. Then, if you think we made a mistake, you can appeal. This letter tells you how to appeal. Do you think you have an emergency? Then, you can ask TennCare for an emergency appeal.

But, if your doctor orders it, UnitedHealthcare Community Plan will pay for this care for you:

2. <amount and type of service approved>.

If your doctor orders it, we think this care is medically necessary. And, we think it will work for your health problem.

Why we won’t pay for <type of service denied>:

TennCare only pays for care that is medically necessary.

UnitedHealthcare Community Plan has guidelines that say when <type of service> is medically necessary. To get <type of service> paid for by UnitedHealthcare Community Plan, you must meet those guidelines. To get a copy of the guidelines, call us at 1-800-690-1606.

<Clinician Name> at UnitedHealthcare Community Plan looked at these medical records to decide if this care is medically necessary for you: <medical record source citation>.

You don’t meet all of the guidelines for <type of service>. Here are the guidelines that you don’t meet:

<Specify in easy-to-understand language each guideline that is not met and explain why each applicable guideline is not met by this member.>

We told <prescriber name> which guidelines you don’t meet. We asked for more facts that show you meet the guidelines or why this care is medically necessary.
SAMPLE

[Complete appropriate option; delete unused option.]

[Option 1:] <Prescriber name> didn’t give us any more facts.

[Option 2:] <Prescriber name> said <detail in easy-to-understand language the additional information provided by the prescriber and why applicable guidelines are still not met.>

Because you don’t meet these guidelines, we don’t think this care is medically necessary for you.

Why the care is not medically necessary:

<Specify what prong(s) of medical necessity definition are not met (select from below) AND explain why each applicable prong is not met by this member. Delete prongs (including legal citations) that are not applicable.>

Your doctor did not say you need this care [TennCare Rule 1200-13-16-.05(1)(a)].

The reason you want this care is not to diagnose or treat a medical problem
[TennCare Rules 1200-13-16-.05(1)(b) and 1200-13-16-.05(2)-(4)].

The care is not safe and effective
[TennCare Rules 1200-13-16-.05(1)(c) and 1200-13-16-.05(5)].

The care is experimental or investigational. (That means there’s not enough proof that it’s safe and that it works for the kind of problem you have.)
[TennCare Rules 1200-13-16-.05(1)(d) and 1200-13-16-.05(6)]

The care is not the least costly way to diagnose or treat your problem that will work
[TennCare Rules 1200-13-16-.05(1)(e) and 1200-13-16-.05(7)].

Federal and State law and the TennCare Rules say we can only pay for care that is medically necessary [Amendment to the TennCare II Demonstration Project extension, approved October 5, 2007; TennCare Rules 1200-13-16-.02 and 1200-13-16-.06(11)].

We asked <prescriber name> to tell us why <type of service approved/non-covered alternative> won’t work for you.

[Option 1:] <Prescriber name> didn’t say that you’ve tried this care or that it won’t work for you.

[Option 2:] <Prescriber name> said <detail in easy-to-understand language the additional information provided by the prescriber and why you still believe the alternative care is appropriate.>

[Option 3:] <Prescriber name> agrees that this is the right care for you.

Do you have questions? Call us at 1-800-690-1606. You may also want to talk to your doctor.

Does your doctor want to talk to someone about this decision? Your doctor can call <Practitioner reviewer name> at <Practitioner reviewer number>.

If you think we made a mistake, you can appeal. You have 30 days after you get this letter to appeal. After 30 days, it’s too late to appeal this decision.
SAMPLE

You are not getting this kind or amount of care from TennCare now. It's care that you want to start getting. So, even if you ask, we can't pay for it during your appeal. BUT, if you win your appeal, you can ask us to pay you back.

How to file a TennCare appeal

When you appeal, you're asking to tell a judge the mistake you think TennCare made. It's called a fair hearing. To get a fair hearing, both of these things must be true:

a. You must give TennCare the facts they need to work your appeal.
b. And, you must tell TennCare the mistake you think we made. That mistake must be something that, if you're right, means that TennCare will pay for this care.

What you must tell TennCare in your appeal:

• Your name (the name of the person who wants the care)
• Your Social Security number or the number on your TennCare card (If you don’t have those numbers, give TennCare your date of birth. Include the month, day and year.)
• The kind of care you are appealing about

To be sure TennCare can reach you about your appeal, please also tell them:

• Your current mailing address
• The name of the person TennCare should call if they have questions about your appeal
• A daytime phone number for that person

If your appeal is for care you’ve already gotten that you think TennCare should pay for, you must also tell TennCare:

• The date you got the care
• The name of the doctor or other place that gave you the care
  (If you have it, include their address and phone number)

Are you asking to be paid back for the care? Then, you must fax or mail TennCare a copy of a receipt that proves you paid for the care.

Don’t have your receipt anymore? Ask your doctor, drug store, or other place that gave you the care for another receipt or printout. A cash register receipt usually won’t show all of the facts TennCare needs.

Are you asking for help because you've gotten a bill for the care? Then, tell TennCare when you first got a bill for the care. And, you must fax or mail TennCare a copy of a bill for the care.

Don’t have your bill anymore? Ask your doctor or other place that gave you the care for another bill. You can’t use a statement from a collections agency or from a credit card company.

What if you don’t give TennCare all of the facts and papers they need? They may not be able to work
There are 3 ways to file an appeal.

**SAMPLE**

**Remember:** You **only** have **30 days** after you get this letter to appeal.

- **Mail.** You can mail an appeal page or a letter about your problem to:

  TennCare Solutions  
P.O. Box 000593  
Nashville, TN 37202-0593

  To print an appeal page off the Internet, go to: [www.tn.gov/tenncare/forms/medappeal.pdf](http://www.tn.gov/tenncare/forms/medappeal.pdf)  
  Or, to have TennCare mail you an appeal page, call them for free at **1-800-878-3192.**

  a. **Fax.** You can fax your appeal page or letter for free to **1-888-345-5575.**

  b. **Call.** You can call TennCare Solutions for free at **1-800-878-3192.**

  Unless you have an emergency, please call during business hours. Business hours are Monday through Friday from 8:00 a.m. until 4:30 p.m. Central Time. If you have an emergency, you
can call anytime.

**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 not be able to wait 90 days. **An emergency means if you don’t get the care or medicine sooner than 90 days:**

  o You will be at risk of serious health problems or you may die.
  o Or, it will cause serious problems with your heart, lungs, or other parts of your body.
  o Or, you will need to go into the hospital.

**Do you still think you have an emergency?** If so, you can ask TennCare for an emergency appeal. Your appeal may go **faster** if your **doctor signs your appeal saying that it’s an emergency.** What if your doctor **doesn’t** sign your appeal, but you **ask** for an emergency appeal? **TennCare will ask your doctor** if your appeal is an emergency. If your doctor says it’s **not** an emergency, TennCare will decide your appeal within 90 days.

**Do you need help with this letter?** Is it because you have a health, mental health, or learning problem or a disability? Or, do you need help in another language? If so, you have a right to get help, and TennCare can help you. Call TennCare Solutions at **1-800-878-3192.**

  - Do you have a mental illness and need help with this letter? 
    The TennCare Advocacy Program can help you. 
    Call them for free at **1-800-758-1638.**

  - If you have a hearing or speech problem you can call us on a **TTY/TDD** machine. 
    Our TTY/TDD number is **1-866-771-7043.**

¿Habla español y necesita ayuda con esta carta? Llámenos gratis al **1-800-878-3192.**
We do not allow unfair treatment in TennCare. No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you’ve been treated unfairly? Do you have more questions or need more help? If you think you’ve been treated unfairly, call the Family Assistance Service Center for free at 1-866-311-4287. In Nashville call 743-2000.
A. Covered Benefits

The following sections describe the services and supplies available under UHCCP subject to the limitations and exclusions listed in this and other sections of the Manual. Covered Services must be Medically Necessary and be performed or prescribed by a practitioner or other appropriate health care professional. Select services/procedures require prior authorization. (See Section IX. Utilization Management Program in this Manual.) For further detail regarding covered benefits, refer to the TennCare Rules, Chapter 1200-13-13-.04 which can be found at: http://www.tn.gov/sos/rules/1200/1200-13/1200-13-13.20120928.pdf.

1. Physical Health Benefits Chart (CRA Section 2.6.1.3)

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT LIMIT</th>
</tr>
</thead>
</table>
| Inpatient Hospital Services                          | Medicaid/Standard Eligible, Age 21 and older: As medically necessary. Inpatient rehabilitation hospital facility services are not covered for adults unless determined by UHCCP to be a cost effective alternative.  
Medicaid/Standard Eligible, Under age 21: As medically necessary, including rehabilitation hospital facility. |
| Outpatient Hospital Services                         | As Medically Necessary.                                                                                                  |
| Physician Inpatient Services                         | As Medically Necessary.                                                                                                  |
| Physician Outpatient Services/Community Health Clinic Services/Other Clinic Services | As Medically Necessary.                                                                                                  |
| TennCare Kids Services                               | Medicaid/Standard Eligible, Age 21 and older: Not covered.  
Medicaid/Standard Eligible, 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. Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with Federal and state requirements. See Section 2.7.6 of the CRA for further details. |
| Preventive Care Services                             | As described in Section 2.7.5.                                                                                           |
| Lab and X-ray Services                               | As medically necessary.                                                                                                  |
| Hospice Care                                         | As medically necessary. Shall be provided by a Medicare-certified hospice.                                                |
| Dental Services                                      | **Dental Services shall be provided by the Dental Benefits Manager.**  
However, the 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 when the dental service is covered by the DBM. This requirement only applies to Medicaid/Standard Eligibles Under age 21. |
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT LIMIT</th>
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<tbody>
<tr>
<td><strong>Vision Services</strong></td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> 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. <strong>Medicaid/Standard Eligible, Under age 21:</strong> Preventive, diagnostic, and treatments services (including eyeglasses) are covered as medically necessary in accordance with TennCare Kids requirements.</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> Covered as medically necessary and in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard). <strong>Medicaid/Standard Eligible, Under age 21:</strong> Covered as medically necessary in accordance with the definition of Home Health Care at Rule 1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for TennCare Standard). Prior authorization required for home health nurse and home health aide services, as described in Rule 1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare Standard).</td>
</tr>
<tr>
<td><strong>Pharmacy Services</strong></td>
<td><strong>Pharmacy services shall be provided by the Pharmacy Benefits Manager (PBM), unless otherwise described below.</strong> The CONTRACTOR shall be responsible for reimbursement of injectable drugs obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. The CONTRACTOR shall require that all home infusion claims contain National Drug Code (NDC) coding and unit information to be paid. Services reimbursed by the CONTRACTOR shall not be included in any pharmacy benefit limits established by TENNCARE for pharmacy services (see CRA Section 2.6.2.2).</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>As medically necessary. Specified DME services shall be covered/non-covered in accordance with TennCare rules and regulations.</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>As medically necessary. Specified medical supplies shall be covered/non-covered in accordance with TennCare rules and regulations.</td>
</tr>
<tr>
<td><strong>Emergency Air And Ground Ambulance Transportation</strong></td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>SERVICE</td>
<td>BENEFIT LIMIT</td>
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<td>-----------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)</td>
<td>Covered non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI of the CRA). Non emergency transportation services shall be provided in accordance with Federal law and the Bureau of TennCare's rules and policies and procedures. TennCare covered services (see definition in Exhibit A to Attachment XI of the CRA) include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the CRA). If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18). The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III of the CRA), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI of the CRA) is not a covered NEMT service. If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements (see CRA Section 2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.</td>
</tr>
<tr>
<td>Renal Dialysis Services</td>
<td>As medically necessary.</td>
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**Notes:**
- Non-emergency medical transportation (NEMT) services are necessary non-emergency transportation services provided to convey members to and from TennCare covered services (see definition in Exhibit A to Attachment XI of the CRA).
- TennCare covered services include services provided to a member by a non-contract or non-TennCare provider if (a) the service is covered by Tennessee's Medicaid State Plan or Section 1115 demonstration waiver, (b) the provider could be a TennCare provider for that service, and (c) the service is covered by a third party resource (see definition in Section 1 of the CRA).
- If a member requires assistance, an escort (as defined in TennCare rules and regulations) may accompany the member; however, only one (1) escort is allowed per member (see TennCare rules and regulations).
- Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, the CONTRACTOR shall not make separate or additional payment to a NEMT provider for an escort.
- The CONTRACTOR is not responsible for providing NEMT to HCBS provided through a 1915(c) waiver program for persons with intellectual disabilities (i.e., mental retardation) and HCBS provided through the CHOICES program. However, as specified in Section 2.11.1.8 in the event the CONTRACTOR is unable to meet the access standard for adult day care (see Attachment III of the CRA), the CONTRACTOR shall provide and pay for the cost of transportation for the member to the adult day care facility until such time the CONTRACTOR has sufficient provider capacity.
- Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile (as defined in Exhibit A to Attachment XI of the CRA) is not a covered NEMT service.
- If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements (see CRA Section 2.7.6.4.6). Failure to comply with the provisions of this Section may result in liquidated damages.
UnitedHealthcare Plan of the River Valley, Inc.
TennCare Provider Administration Manual 04.2016
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<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT LIMIT</th>
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<tbody>
<tr>
<td>Private Duty Nursing</td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> Covered as medically</td>
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<tr>
<td></td>
<td>necessary in accordance with the definition of Private Duty Nursing at Rule</td>
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<td></td>
<td>1200-13-13-.01 (for TennCare Medicaid) and Rule 1200-13-14-.01 (for</td>
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<td></td>
<td>TennCare Standard), when prescribed by an attending physician for</td>
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<td></td>
<td>treatment and services rendered by a Registered Nurse (R.N.) or a licensed</td>
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<td></td>
<td>practical nurse (L.P.N.) who is not an immediate relative. Private duty</td>
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<td></td>
<td>nursing services are limited to services that support the use of</td>
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<td></td>
<td>ventilator equipment or other life sustaining technology when constant</td>
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<td></td>
<td>nursing supervision, visual assessment, and monitoring of both equipment</td>
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<td></td>
<td>and patient are required. Prior authorization required, as described Rule</td>
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<tr>
<td></td>
<td>1200-13-13-.04 (for TennCare Medicaid) and 1200-13-14-.04 (for TennCare</td>
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<tr>
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<td>Standard).</td>
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<tr>
<td></td>
<td><strong>Medicaid/Standard Eligible, Under age 21:</strong> Covered as medically</td>
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<td></td>
<td>necessary in accordance with the definition of Private Duty Nursing at Rule</td>
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<tr>
<td></td>
<td>1200-13-13-.01 (for TennCare Medicaid) and 1200-13-14-.01 (for TennCare</td>
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<td></td>
<td>Standard), when prescribed by an attending physician for treatment and</td>
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<td>services rendered by a registered nurse (R.N.) or a licensed practical</td>
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<td></td>
<td>nurse (L.P.N.), who is not an immediate relative. Prior authorization</td>
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<td></td>
<td>required as described Rule 1200-13-13-.04 (for TennCare Medicaid) and</td>
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<td></td>
<td>1200-13-14-.04 (for TennCare Standard).</td>
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<tr>
<td>Speech Therapy</td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> Covered as medically</td>
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<tr>
<td></td>
<td>necessary by a Licensed Speech Therapist to restore speech (as long as</td>
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<td></td>
<td>there is continued medical progress) after a loss or impairment. The loss</td>
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<td>or impairment must not be caused by a mental, psychoneurotic or personality</td>
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<td></td>
<td>disorder.</td>
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<td></td>
<td><strong>Medicaid/Standard Eligible, Under age 21:</strong> Covered as medically</td>
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<td></td>
<td>necessary in accordance with TennCare Kids requirements.</td>
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<tr>
<td>Occupational Therapy</td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> Covered as medically</td>
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<tr>
<td></td>
<td>necessary when provided by a Licensed Occupational Therapist to restore,</td>
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<td></td>
<td>improve, or stabilize impaired functions.</td>
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<td></td>
<td><strong>Medicaid/Standard Eligible, Under age 21:</strong> Covered as medically</td>
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<tr>
<td></td>
<td>necessary in accordance with TennCare Kids requirements.</td>
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<tr>
<td>Physical Therapy</td>
<td><strong>Medicaid/Standard Eligible, Age 21 and older:</strong> Covered as medically</td>
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<td></td>
<td>necessary when provided by a Licensed Physical Therapist to restore,</td>
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<tr>
<td></td>
<td>improve, or stabilize impaired functions.</td>
</tr>
<tr>
<td></td>
<td><strong>Medicaid/Standard Eligible, Under age 21:</strong> Covered as medically</td>
</tr>
<tr>
<td></td>
<td>necessary in accordance with TennCare Kids requirements.</td>
</tr>
</tbody>
</table>

2. Additional Physical Health Benefits

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography Screening</td>
<td>UHCCP provides mammography screenings a minimum of: once for ages 35-40;</td>
</tr>
<tr>
<td></td>
<td>every two years or more frequently on physician recommendation for ages</td>
</tr>
<tr>
<td></td>
<td>40-50; and annually for ages 50 and older. The Facility where the</td>
</tr>
<tr>
<td></td>
<td>mammogram was performed shall provide the patient notice as required by</td>
</tr>
<tr>
<td></td>
<td>The Breast Cancer Prevention Act (TCA 63-6-2).</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Treatment</td>
<td>UHCCP provides coverage for the treatment of PKU, including licensed</td>
</tr>
<tr>
<td></td>
<td>professional medical services and special dietary formulas.</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>UHCCP provides coverage for diabetic equipment, supplies, and outpatient</td>
</tr>
<tr>
<td></td>
<td>self-management training and education, including medical nutrition</td>
</tr>
<tr>
<td></td>
<td>counseling, when medically necessary.</td>
</tr>
</tbody>
</table>
3. Behavioral Health Benefits Chart (CRA Section 2.6.1.4)

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>BENEFIT LIMIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Inpatient Hospital Services (including physician services)</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>Outpatient Mental Health Services (including physician services)</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>Inpatient, Residential &amp; Outpatient Substance Abuse Benefits¹</td>
<td>Covered as medically necessary.</td>
</tr>
<tr>
<td>Mental Health Case Management</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>Psychiatric-Rehabilitation Services</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>Behavioral Health Crisis Services</td>
<td>As necessary.</td>
</tr>
<tr>
<td>Lab and X-ray Services</td>
<td>As medically necessary.</td>
</tr>
<tr>
<td>Non-emergency Medical Transportation (including Non-Emergency Ambulance Transportation)</td>
<td>Follows physical health guidelines. See chart in Chapter V, Section A-1.</td>
</tr>
</tbody>
</table>

¹When medically appropriate, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services. Methadone clinic services are not covered for adults.

B. Benefit Exclusions

Effective July 1, 2011, the Bureau of TennCare updated the Exclusion section of the TennCare Rules located at http://www.tn.gov/sos/rules/1200/1200-13/1200-13-13.20120928.pdf. The items on the Exclusions list are specifically excluded from coverage unless determined by UHCCP to be a cost effective alternative when providing medically necessary care as stated in Rule 1200-13-13-.10(2).

UHCCP has provided the Exclusions list in this Manual; however the Bureau of TennCare may add or delete services or supplies at their discretion. As stated above, the Exclusions list is available on the Bureau of TennCare website; therefore, providers can view the latest list as necessary.

The following list includes, but is not limited to services, products and supplies that are specifically excluded from coverage under the TennCare Section 1115(b) waiver program unless approved as a cost effective service for medically necessary care as stated in Rule 1200-13-13-.10(2). Some of these services may be covered under the CHOICES program or outside TennCare under a Section 1915(c) Home and Community Based Services waiver when provided as
part of an approved plan of care, in accordance with the appropriate TennCare Home and Community Based Services rule.

**TennCare Exclusions per TennCare Rule 1200-13-13-.10**

Services, products, and supplies that are specifically excluded from coverage except as medically necessary for children under the age of 21:

1. Air cleaners, purifiers, or HEPA filters
2. Audiolological therapy or training
3. Augmentative communication devices
4. Beds and bedding equipment as follows:
   (i) Powered air flotation beds, air fluidized beds (including Clinitron beds), water pressure mattress, or gel mattress. For persons age 21 and older: Not covered unless a member has both severely impaired mobility (i.e., unable to make independent changes in body position to alleviate pain or pressure) and any stage pressure ulcer on the trunk or pelvis combined with at least one of the following: impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.
   (ii) Bead beds, or similar devices
   (iii) Bed boards
   (iv) Bedding and bed casings
   (v) Ortho-prone beds
   (vi) Oscillating beds
   (vii) Pillows, hypoallergenic
   (viii) Springbase beds
   (ix) Vail beds, or similar bed
5. Bed baths and Sitz baths
6. Biofeedback
7. Chiropractor’s services
8. Cushions, pads, and mattresses as follows:
   (i) Aquamatic K Pads
   (ii) Elbow protectors
(iii) Heat and massage foam cushion pads
(iv) Heating pads
(v) Heel protectors
(vi) Lamb’s wool pads
(vii) Steam packs

9. Diagnostic tests conducted solely for the purpose of evaluating the need for a service which is excluded from coverage under these rules.

10. Ear plugs

11. Floor standers

12. Food supplements and substitutes including formulas

   For persons 21 years of age and older: Not covered, except that Parenteral Nutrition formulas, Enteral Nutrition formulas for tube feedings and phenylalanine-free formulas (not foods) used to treat PKU, as required by T.C.A. §56-7-2505, are covered for adults. In addition, oral liquid nutrition may be covered when medically necessary for adults with swallowing or breathing disorders who are severely underweight (BMI < 15 kg/m²) and physically incapable of otherwise consuming a sufficient intake of food to meet basic nutritional requirements.

13. Hearing services, including the prescribing, fitting, or changing of hearing aids

14. Humidifiers (central or room) and dehumidifiers

15. Inpatient rehabilitation facility services

16. Medical supplies, over-the-counter, as follows:
   (i) Alcohol, rubbing
   (ii) Band-aids
   (iii) Cotton balls
   (iv) Eyewash
   (v) Peroxide
   (vi) Q-tips or cotton swabs

17. Methadone clinic services

18. Nutritional supplements and vitamins, over-the-counter, except that prenatal vitamins for pregnant women and folic acid for women of childbearing age are covered
19. Orthodontic services, except as defined in Rule 1200-13-13-.04(1)(b)5. or 1200-13-14.04(1)(b)5.

20. Certain pharmacy items as follows:

(i) Agents for weight loss or weight gain.

(ii) Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.

(iii) Agents when used for cosmetic purposes or hair growth

(iv) Agents when used for the symptomatic relief of cough and colds

(v) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

(vi) Nonprescription drugs

(vii) Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or his designee.

(viii) TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee’s age. TennCare shall not cover experimental or investigational drugs which have not received final approval from the FDA.

(i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy. For enrollees who are pregnant while receiving this dosage, the six-month period does not begin until the enrollee is no longer pregnant. At the end of either six month period, the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

(ix) Buprenorphine products for opiate addiction treatment for persons aged 21 and older are restricted as follows:

(i) Dosage shall not exceed sixteen milligrams (16 mg) per day for a period of up to six (6) months from the initiation of therapy. For enrollees who are pregnant while receiving this dosage, the six-month period does not begin until the enrollee is no longer pregnant. At the end of either six month period, the covered dosage amount shall not exceed eight milligrams (8 mg) per day.

(ii) Therapy shall be limited to a total lifetime period of coverage not to exceed a total of 732 therapy days, which do not have to be consecutive. For enrollees who are pregnant on day 732 of treatment, the treatment may continue until the enrollee is no longer pregnant.

(iii) Effective October 1, 2015 through March 28, 2016, enrollees who have exceeded 549 days of treatment will receive coverage for an additional 183 days of therapy prior to exhaustion of their lifetime coverage limits.

(x) Sedative hypnotic medications for persons aged 21 and older shall not exceed fourteen (14) pills per month for sedative hypnotic formulations in pill form such as Ambien and Lunesta, one hundred forty milliliters (140 ml) per month of chloral hydrate, or one (1) bottle every sixty (60) days of Zolpidem.

(xi) Allergy medications.
21. Purchase, repair, or replacement of materials or equipment when the reason for the purchase, repair, or replacement is the result of member abuse

22. Purchase, repair, or replacement of materials or equipment that has been stolen or destroyed except when the following documentation is provided:
   (i) Explanation of continuing medical necessity for the item, and
   (ii) Explanation that the item was stolen or destroyed, and
   (iii) Copy of police, fire department, or insurance report if applicable

23. Radial keratotomy

24. Reimbursement to a provider or member for the replacement of a rented durable medical equipment (DME) item that is stolen or destroyed

25. Repair of DME items not covered by TennCare

26. Repair of DME items covered under the provider’s or manufacturer’s warranty

27. Repair of a rented DME item

28. Speech, language, and hearing services to address speech problems caused by mental, psychoneurotic, or personality disorders

29. Standing tables

30. Vision services for persons 21 years of age and older that are not needed to treat a systemic disease process including, but not limited to:
   (i) Eyeglasses, sunglasses, and/or contact lenses for persons aged 21 and older, including eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, sunglasses, and/or contact lenses; procedures performed to determine the refractive state of the eye(s); one pair of cataract glasses or lenses is covered for adults following cataract surgery
   (ii) LASIK
   (iii) Orthoptics
   (iv) Vision perception training
   (v) Vision therapy
Services, products, and supplies that are specifically excluded from coverage under the TennCare program.

1. Alcoholic beverages

2. Animal therapy including, but not limited to:
   (i) Dolphin therapy
   (ii) Equine therapy
   (iii) Hippo therapy
   (iv) Pet therapy

3. Art therapy

4. Autopsy

5. Bathtub equipment and supplies as follows:

6. Beds and bedding equipment as follows:
   (i) Adjust-a-Beds, lounge beds, or similar devices
   (ii) Waterbeds

7. Bioenergetic therapy

8. Body adornment and enhancement services including, but not limited to:
   (i) Body piercing
   (ii) Breast augmentation
   (iii) Breast capsulectomy
   (iv) Breast implant removal
   (v) Ear piercing
   (vi) Hair transplantation, and agents for hair growth
   (vii) Tattoos or removal of tattoos
   (viii) Tongue splitting or repair of tongue splitting
   (ix) Wigs or hairpieces
9. Breathing equipment as follows:
   (i) Intrapulmonary Percussive Ventilators (IPVs)
   (ii) Spirometers, except for peak flow meters for medical management of asthma
   (iii) Vaporizers
10. Carbon dioxide therapy
11. Care facilities or services, the primary purpose of which is non-medical, including, but not limited to:
   (i) Day care
   (ii) Evening care centers
   (iii) Respite care, except as a component of Mental Health Crisis Services benefits or Hospice Care benefits as provided at Rule 1200-13-13-.04(1)(b).
12. Carotid body tumor, excision of, as treatment for asthma
13. Chelation therapy, except for the treatment of heavy metal poisoning or secondary hemochromatosis in selected settings. Chelation therapy for treatment of arteriosclerosis or autism is not covered. Chelation therapy for asymptomatic individuals is not covered. In the case of lead poisoning, the lead levels must be extremely high. For children, a minimum level of 45 ug/dl is recommended. Because chelation therapy and its after-effects must be continuously monitored for possible adverse reactions, chelation therapy is covered only in inpatient or outpatient hospital settings, renal dialysis facilities, and skilled nursing facilities. It is not covered in an office setting, an ambulatory surgical center, or a home setting.
14. Clothing, including adaptive clothing
15. Cold therapy devices
16. Comfort and convenience items including, but not limited to:
   (i) Corn plasters
   (ii) Garter belts
   (iii) Incontinence products (diapers/liners/underpads) for persons younger than 3 years of age
   (iv) Support stockings, when light or medium weight or prescribed for relief of tired or aching legs or treatment of spider/varicose veins. Surgical weight stockings prescribed by a doctor or other qualified licensed health care practitioner for the treatment of chronic foot/ankle swelling, venous insufficiencies, or other medical conditions and thrombo-embolic deterrent support stockings for pre- and post-surgical procedures are covered as medically necessary.
17. Computers, personal, and peripherals including, but not limited to printers, modems, monitors, scanners, and software, including their use in conjunction with an Augmentative Communication Device

18. Convalescent care.

19. Cosmetic dentistry, cosmetic oral surgery, and cosmetic orthodontic services

20. Cosmetic prosthetic devices

21. Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem, including scar revision. The following services are not considered cosmetic services:

   (i) Reconstructive surgery to correct the results of an injury or disease

   (ii) Surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function

   (iii) Surgery to reconstruct a breast after mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure

   (iv) In accordance with Tennessee law, surgery of the non-diseased breast following mastectomy and reconstruction to create symmetrical appearance*

   (v) Surgery for the improvement of the functioning of a malformed body member

   (vi) Reduction mammoplasty, when the minimum amount of breast material to be removed is equal to or greater than the 22nd percentile of the Schnur Sliding Scale based on the individual’s body surface area.

22. Dance therapy

23. Dental services for adults age 21 and older

24. Services provided solely or primarily for educational purposes, including, but not limited to:

   (i) Academic performance testing

   (ii) Educational tests and training programs

   (iii) Habilitation

   (iv) Job training

   (v) Lamaze classes

   (vi) Lovaas therapy

   (vii) Picture illustrations

   (viii) Remedial education
(ix) Sign language instruction
(x) Special education
(xi) Tutors

25. Encounter groups or workshops

26. Environmental modifications including, but not limited to:

   (i) Air conditioners, central or unit
   (ii) Micronaire environmentals, and similar devices
   (iii) Pollen extractors
   (iv) Portable room heaters
   (v) Vacuum systems for dust filtering
   (vi) Water purifiers
   (vii) Water softeners

27. Exercise equipment including, but not limited to:

   (i) Exercise equipment
   (ii) Exercycles (including cardiac use)
   (iii) Functional electrical stimulation
   (iv) Gravitronic traction devices
   (v) Gravity guidance inversion boots
   (vi) Parallel bars
   (vii) Pulse tachometers
   (viii) Tilt tables
   (ix) Training balls
   (x) Treadmill exercisers
   (xi) Weighted quad boots
28. Food and food products (distinct from food supplements or substitutes, as defined in rule 1200-13-13-.10(3)(a)12. including but not limited to specialty food items for use in diets such as:

(i) Low-phenylalanine or phenylalanine-free
(ii) Gluten-free
(iii) Casein-free
(iv) Ketogenic

29. Generators and auxiliary power equipment that may be used to provide power for covered medical equipment or for any purpose

30. Grooming services including, but not limited to:

(i) Barber services
(ii) Beauty services
(iii) Electrolysis
(iv) Hairpieces or wigs
(v) Manicures
(vi) Pedicures

31. Hair analysis

32. Home health aide services or services from any other individual or agency that are for the primary purpose of safety monitoring

33. Home modifications and items for use in the home

(i) Decks
(ii) Enlarged doorways
(iii) Environmental accessibility modifications such as grab bars and ramps
(iv) Fences
(v) Furniture, indoor or outdoor
(vi) Handrails
(vii) Meals
(viii) Overbed tables
(ix) Patios, sidewalks, driveways, and concrete slabs
(x) Plexiglass
(xi) Plumbing repairs
(xii) Porch gliders
(xiii) Rollabout chairs
(xiv) Room additions and room expansions
(xv) Telephone alert systems
(xvi) Telephone arms
(xvii) Telephone service in home
(xviii) Televisions
(xix) Tilt tables
(xx) Toilet trainers and potty chairs. Positioning commodes and toilet supports are covered as medically necessary.
(xxi) Utilities (gas, electric, water, etc.)

34. Hospital inpatient items that are not directly related to the treatment of an injury or illness (such as radios, TVs, movies, telephones, massage, guest beds, haircuts, hair styling, guest trays, etc.)

35. Hotel charges, unless pre-approved in conjunction with a transplant or as part of a non-emergency transportation service

36. Hypnosis or hypnotherapy

37. Icterus index

38. Infant/child car seats, except that adaptive car seats may be covered for a person with disabilities such as severe cerebral palsy, spina bifida, muscular dystrophy, and similar disorders who meets all of the following conditions:
   (i) Cannot sit upright unassisted, and
   (ii) Infant/child care seats are too small or do not provide adequate support, and
   (iii) Safe automobile transport is not otherwise possible.
39. Infertility or impotence services including, but not limited to:

(i) Artificial insemination services

(ii) Purchase of donor sperm and any charges for the storage of sperm

(iii) Purchase of donor eggs, and any charges associated with care of the donor required for donor egg retrievals transfers of gestational carriers of

(iv) Cryopreservation and storage of cryopreserved embryos

(v) Services associated with a gestational carrier program (surrogate parenting) for the recipient or the gestational carrier

(vi) Fertility drugs

(vii) Home ovulation prediction kits

(viii) Services for couples in which one of the partners has had a previous sterilization procedure, with or without reversal

(ix) Reversal of sterilization procedures

(x) Any other service or procedure intended to create a pregnancy

(xi) Testing and/or treatment, including therapy, supplies, and counseling, for frigidity or impotence

40. Lamps such as:

(i) Heating lamps

(ii) Lava lamps

(iii) Sunlamps

(iv) Ultraviolet lamps

41. Lifts as follows:

(i) Automobile van lifts

(ii) Electric powered recliner, elevating seats, and lift chairs

(iii) Elevators

(iv) Overhead or ceiling lifts, ceiling track system lifts, or wall mounted lifts when installation would require significant structural modification and/or renovation to the dwelling (e.g., moving walls, enlarging passageways, strengthening ceilings and supports). The request for prior authorization must include a specific breakdown of equipment and installation costs, specifying all required structural modifications (however minor) and the cost associated there to.
(v) Stairway lifts, stair glides, and platform lifts, including but not limited to Wheel-O-Vators

42. Ligation of mammary arteries, unilateral or bilateral

43. Megavitamin therapy

44. Motor vehicle parts and services including, but not limited to:
   
   (i) Automobile controls
   
   (ii) Automobile repairs or modifications

45. Music therapy

46. Nail analysis

47. Naturopathic services

48. Necropsy

49. Organ and tissue transplants that have been determined experimental or investigational

50. Organ and tissue donor services provided in connection with organ or tissue transplants covered pursuant to Rule 1200-13-13-.04(1)(b)23., including, but not limited to:

   (i) Transplants from a donor who is a living TennCare member and the transplant is to a non-TennCare member

   (ii) Donor services other than the direct services related to organ procurement (such as, hospitalization, physician services, anesthesia)

   (iii) Hotels, meals, or similar items provided outside the hospital setting for the donor

   (iv) Any costs incurred by the next of kin of the donor

   (v) Any services provided outside of any “bundled rates” after the donor is discharged from the hospital

51. Oxygen, except when provided under the order of a physician and administered under the direction of a physician

52. Oxygen, preset system (flow rate not adjustable)

53. Certain pharmacy items as follows: DESI, LTE, and IRS drugs

54. Play therapy

55. Primal therapy

56. Prophylactic use of stainless steel crowns

57. Psychodrama
58. Psychogenic sexual dysfunction or transformation services
59. Purging
60. Recertification of patients in Level 1 and Level II Nursing Facilities
61. Recreational therapy
62. Religious counseling
63. Retreats for mental disorders
64. Rolfing
65. Routine health services which may be required by an employer; or by a facility where an individual lives, goes to school, or works; or by the member’s intent to travel
   (i) Drug screenings
   (ii) Employment and pre-employment physicals
   (iii) Fitness to duty examinations
   (iv) Immunizations related to travel or work
   (v) Insurance physicals
   (vi) Job related illness or injury covered by workers’ compensation
66. Sensitivity training or workshops
67. Sensory integration therapy and equipment used in sensory integration therapy including, but not limited to:
   (i) Ankle weights
   (ii) Floor mats
   (iii) Mini-trampolines
   (iv) Poofc hairs
   (v) Sensory balls
   (vi) Sky chairs
   (vii) Suspension swings
   (viii) Trampolines
   (ix) Therapy balls
(x) Weighted blankets or weighted vests

68. Sensory stimulation services

69. Services provided by immediate relatives, i.e., a spouse, parent, grandparent, stepparent, child, grandchild, brother, sister, half brother, half sister, a spouse’s parents or stepparents, or members of the recipient’s household

70. Sex change or transformation surgery

71. Sexual dysfunction or inadequacy services and medicine, including drugs for erectile dysfunctions and penile implant devices

72. Sitter Services.

73. Speech devices as follows:
   (i) Phone mirror handivoice
   (ii) Speech software
   (iii) Speech teaching machines

74. Sphygmomanometers (blood pressure cuffs)

75. Stethoscopes

76. Supports
   (i) Cervical pillows
   (ii) Orthotrac pneumatic vests

77. Thermograms

78. Thermography

79. Time involved in completing necessary forms, claims, or reports

80. Tinnitus maskers

81. Toy equipment such as: Flash switches (for toys)

82. Transportation costs as follows:
   (i) Transportation to a provider who is outside the geographical access standards that the MCC is required to meet when a network provider is available within such geographical access standards or, in the case of Medicare beneficiaries, transportation to Medicare providers who are outside the geographical access standards of the TennCare program when there are Medicare providers available within those standards
(ii) Mileage reimbursement, car rental fees, or other reimbursement for use of a private vehicle unless prior authorized by the MCC in lieu of contracted transportation services

(iii) Transportation back to Tennessee from vacation or other travel out-of-state in order to access non-emergency covered services (unless authorized by the MCC)

(iv) Any non-emergency out-of-state transportation, including airfare, that has not been prior authorized by the MCC. This includes the costs of transportation to obtain out-of-state care that has been authorized by the MCC. Out-of-state transportation must be prior authorized independently of out-of-state care.

83. Transsexual surgery

84. Vagus nerve stimulators, except after conventional therapy has failed in treating partial onset of seizures.

85. Weight loss or weight gain and physical fitness programs including, but not limited to:

(i) Dietary programs of weight loss programs, including, but not limited to, Optifast, Nutrisystem, and other similar programs or exercise programs. Food supplements will not be authorized for use in weight loss programs or for weight gain.

(ii) Health clubs, membership fees (e.g., YMCA)

(iii) Marathons, activity and entry fees

(iv) Swimming pools

86. Wheelchairs as follows:

(i) Wheelchairs defined by CMS as power operated vehicles (POVs), namely, scooters and devices with three (3) or four (4) wheels that have tiller steering and limited seat modification capabilities (i.e., provide little or no back support). Powered wheelchairs, meaning four (4) wheeled, battery operated vehicles that provide back support and that are steered by an electronic device or joystick that controls direction and turning, are covered as medically necessary.

(ii) Standing wheelchairs

(iii) Stair-climbing wheelchairs

(iv) Recreational wheelchairs

87. Whirlpools and whirlpool equipment such as:

(i) Action bath hydro massage

(ii) Aero massage

(iii) Aqua whirl

(iv) Aquasage pump, or similar devices
(v) Hand-D-Jets, or similar devices
(vi) Jacuzzis, or similar devices
(vii) Turbojets
(viii) Whirlpool bath equipment
(ix) Whirlpool pumps

*Reconstructive Breast Surgery is covered in accordance with TCA 56-7-2507, which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy, as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-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.
VI. Billing and Reimbursement

A. How to File a Claim with UnitedHealthcare Community Plan

UHCCP provider contracts prefers that claims be submitted electronically. Electronic claims reduce errors and shorten payment cycles. For electronic claims submission requirements, please see our companion documents located at http://www.uhccommunityplan.com/health-professionals/TN/electronic-data-interchange. This documentation should be shared with your software vendor. UHCCP’s standard turnaround time for clean claims is 10 business days, measured from date of receipt. Please allow 30 days before inquiring about claims status.

1. Paper Claims Submission

When completing a paper claim, please reference the most recent edition of the Manual or refer to the Data Elements required for submitting complete claims.

- CMS-1500 Physician’s Manual
- UB-04 (CMS-1450) Hospital Manual
- Tennessee Uniform Procedure Coding Manual
- ICD-10 Manual (or its successor)

Paper claims should be submitted to the following address:
UnitedHealthcare Community Plan
PO Box 5220
Kingston, NY 12402-5220

2. Electronic Claims Submission

To submit claims electronically, have your office software vendor or clearinghouse to request enrollment for electronic claim submission to UnitedHealthcare Plan of the River Valley, Inc. Payer ID 95378 via connection to UHCCP's clearinghouse Ingenix Connectivity Solutions (ICS), or you can contact UHCCP EDI Support Services at:

UnitedHealthcare Community Plan
EDI Support Services
800-210-8315
ac_edi_ops@uhc.com

Companion Guides and informational materials on EDI, EFT and ERA can be located at http://www.uhccommunityplanet.com/health-professionals/TN/electronic-data-interchange.

2.1 Importance and Usage of EDI Acknowledgement/Status Reports

Software vendor reports only show that the claim left the provider’s office and was either accepted or rejected by the vendor. Your software vendor report does not confirm claims have been received or accepted at clearinghouse or by UHCCP. There are reports that will allow you to know the status of your claims. These reports are the Clearinghouse Acknowledgement Report and the UHCCP Status Report. Acknowledgement reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached UHCCP for payment or if claim(s) have been rejected for an error or additional information.
Providers MUST review their reports, Clearinghouse Acknowledgement Reports and UHCCP’s Status Reports to eliminate processing delays and timely filing penalties for claims that have not reached UHCCP.

2.2 Obtaining EDI reports

Your software vendor is responsible for establishing your connectivity to our clearinghouse ENSHealth, www.ENSHealth.com and will instruct you how your office will receive Clearinghouse Acknowledgement Reports.

2.3 Correcting errors communicated through EDI reports

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that Clearinghouse Acknowledgement Reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and a claim correcting the rejection reason is not received by UHCCP within 120 days from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

2.4 EDI Companion Documents

UHCCP’s Companion Guides are intended to convey information that is within the framework of the ASC X12N Implementation Guides(IG) adopted by HIPAA. The companion guides identify the data content being requested when data is electronically transmitted.


UHCCP utilizes the companion guides to:

• Clarify data content that meets the needs of the UHCCP’s business purposes when the IG allows multiple choices.

• Outline which situational elements UHCCP requires.

• Provide values that UHCCP will return in outbound transactions.

Section 1 provides general information.

Section 2 provides specific details pertinent to each transaction. These documents should be shared with your software vendor for any programming and field requirements. As UHCCP makes information available on various transactions, we will identify our requirements for those transactions in Section 2 of the Companion Guide. Additional comments may also be added to Section 1 as needed. Changes will be included in Change Summary located in each section of the Companion Document. Please routinely visit our website to ensure you have the most recent information.

3. Claims – Required Information and Formatting

3.1 Tax Identification Numbers/Provider IDs

It is a Federal requirement that the tax ID number is affixed on all claims for consideration – paper and electronic.
You must submit standard transactions using your National Provider Identifier (NPI).
If you have any questions about IDs, please contact your local office or EDI Customer Service at 800-210-8315 or AC_EDI_OPS@uhc.com or the successor e-mail address.

3.2 Claims Format
All claims for medical or hospital services must be submitted using the standard CMS-1500 (formerly known as HCFA-1500), UB04 (also known as CMS-1450), or respective electronic format. UHCCP recommends the use of black ink when completing a CMS-1500. Black ink on a red CMS-1500 form will allow for optimal scanning into the UHCCPs’ claims processing system.

No matter which format you use to submit the claim, ensure that all appropriate secondary diagnosis codes are captured and indicated for line items. This allows for proper reporting on encounter data.

3.3 Span Dates
Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission. Please refer to the companion document for electronic submission instructions on our website at: http://www.uhccommunityplan.com/health-professionals/TN/electronic-data-interchange

3.4 Claims Submission Rules
The following claims MUST be submitted on paper due to required attachments:

- Timely filing reconsideration requests
- Services for which reimbursement policies require additional documentation
- TennCare Sterilization/Abortion/Hysterectomies

The following claims may be submitted electronically without specific rules:

- 59 Modifier
- TennCare ER
- TennCare Baby

Paper claim specific rules include:

- Corrected Claims may be submitted electronically; however the words “corrected claims” must be in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Unlisted Procedure Codes as referenced in reimbursement policies.
- OT/ST/PT/Dialysis/MHSA claims require the Date of Service by line item.

UHCCP does not accept span dates for these types of claims.
• Secondary COB claims may be submitted if the following “required” fields are included on the electronic submission:
  — Institutional: Payer Prior Payment, Medicare Total Paid Amount, if secondary payer is Medicare, Total Covered Amount, Total Denied Amount
  — Non-Professional: Payer Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (Amount that the payer paid to the member not the provider)
  — Dental: Payer Paid Amount, Patient Responsibility Amount, Discount Amount (Contractual Discount Amount of Other Payer), Patient Paid Amount (Amount that the payer paid to the member not the provider)

4. Claims – Guidelines

4.1 Provider Responsibilities with Member Cost Sharing

As stated in Chapter IV-C of this Manual, TennCare Medicaid members do not have cost sharing responsibilities for TennCare coverage and covered services. However, TennCare Medicaid adults (age 21 and older) who receive pharmacy services have nominal copays for these services. Members may not be denied a service for inability to pay a copay. There is no Out-of-Pocket Maximum on copays. See TennCare Medicaid Rule 1200-13-13-.05.

Under some circumstances TennCare Standard members may have copayment obligations. However, providers may not refuse to deliver a covered service to a member because of the member’s failure or inability to make his copay. See TennCare Standard Rule 1200-13-14-.04

Providers participating in the TennCare program are prohibited from billing or attempting to collect payment from TennCare members for TennCare-authorized and/or Covered Services other than applicable copayments and special fees permitted by TennCare Rules and Regulations 1200-13-12-.08, 1200-13-13-.08 (Medicaid) or 1200-13-14-.08 (Standard). Additional guidance can be found in the TennCare policy manual located on the TennCare Bureau website at http://tn.gov/tenncare/forms/pro08001.pdf. As directed by the Bureau of TennCare, UHCCP shall ensure that the participating provider ceases all activity to bill a UHCCP member by issuing a “Cease to Bill Notice” to the provider.

4.2 Effective Date/Termination Date

Coverage will be effective on the date the member is effective with UHCCP, as assigned by the Bureau of TennCare. Coverage will terminate on the date the member’s benefit plan terminates with UHCCP. If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required.

Please be aware that effective dates for TennCare members are frequently revised, as individual members re-verify with the Department of Human Services. You should verify eligibility at each visit, to ensure coverage for services.

4.3 Overpayments

Overpayments can happen for many reasons, including:

• Medicare paid as Primary
• Another Party paid
• UHCCP already paid
• Member paid
• Member was determined to be ineligible at time of service

All refunds of overpayments in response to overpayment refund requests received from UHCCP, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter. Please include appropriate documentation that outlines the overpayment, including member’s name, Member ID number, date of service and amount paid. If possible, please also include a copy of the remittance advice that corresponds with the payment from UHCCP. If the refund is due as a result of coordination of benefits with another carrier, please provide a copy of the other carrier’s EOB with the refund. When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician, health care professional, facility or ancillary provider. In the case of an overpayment, we will implement a claim reconsideration and request a refund within at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it. If you disagree with a claim reconsideration, our request for an overpayment refund, or a recovery made to recoup the overpayment, you can appeal the determination (see Chapter VI, Section C Provider Dispute Processes).

Section 6402 of the Healthcare Reform Act stipulates that providers who are participating under UHCCP, in our TennCare program, must return to UHCCP any overpayments identified by the provider within sixty (60) days of the date that the provider identifies the overpayment. Failure of a provider to be in compliance with this law could result in actions being taken by both UHCCP and the Tennessee Bureau of Investigations for potential fraudulent activity. After 60 days, the overpayment is considered a false claim, which triggers potential penalties under the False Claims Act. In order to avoid such liability, providers and other entities receiving reimbursement under Medicare or Medicaid programs, including those under UHCCP, should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the Affordable Care Act.

If you have a question about an overpayment or you think you may have identified an overpayment, please contact Customer Service at 800-690-1606 or complete the UHCCP Recoup Request Form located in the Forms Appendix or on our website at: http://www.uhcommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-RecoupRequestForm.pdf.

4.4 Subrogation

At the time of service, please submit all claims to UHCCP for processing. See Coordination of Benefits for additional information.
4.5 Retro-Eligible Process for Filing Claims

There are times when the TennCare Bureau grants members retro eligibility coverage upon their approval for TennCare benefits. If you are submitting a claim for a member whose TennCare benefits were retroactively assigned after your practice has delivered services, prepare and complete an accurate CMS-1500 (formerly HCFA) or UB-04 claim form. You may submit a paper or electronic claim.

If retro eligible authorization review is needed, the Medical Review Unit will request documentation from the provider via fax. UHCCP will not deny payment due to lack of prior authorization for medically necessary covered services rendered prior to eligibility being established.

If a member is retroactively enrolled, a claim must be submitted within 120 days of the date TennCare informs UHCCP of the member’s eligibility.

4.6 Corrected Claims

You can correct both professional and institutional claims by making the necessary changes in your practice management system in order for the corrected claim to be printed or submitted electronically. Please include the entire claim as originally submitted (even line items that were previously paid correctly). Any partial corrected claims will be denied and a request for the entire claim will be returned.

Enter “Corrected Claim” in the comments field on your claim form. Check the practice management system help desk or software vendor for any instructions on where to enter this information in your system. If you do not have this feature at this time, stamp or write ‘Corrected Claim’ on the CMS-1500 form.

Beginning with claims for dates of service January 1, 2013 and following, except for 1) recovery of overpayments as required pursuant to Section 6402 of the Affordable Care Act and TENNCARE policy; and 2) retrospective adjustments of a nursing facility’s per diem rate(s), paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 120 days of the date of payment notification. Corrections to a claim should only be submitted if the original claim information was wrong or incomplete.

Correcting Electronic Claims

You can correct professional and institutional electronic claims as follows:

• Professional claims CMS-1500 or 837P:
  • Indicate Corrected Claim in the Claim Information NTE Segment field in the electronic file (Loop 2300) **Do not use Loop 2400 (Service Line level NTE Segment)
  • Hand-corrected claim resubmissions are not accepted
  • Institutional claims UB-04 or 837I:
    • Submit with the third digit of Type of Bill as 7 to indicate Frequency code 7.
    • Indicate Corrected Claim in form locator 80 (NTE/Remarks)
    • Resubmit all original lines and charges as well as the corrected or additional information using bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim
Correcting Paper Claims

You can correct professional and institutional paper claims as follows:

- Professional claims CMS-1500: Stamp "Corrected Billing" on the CMS 1500 form. Indicate Corrected Claim in form locator 19. Complete the Provider Dispute Form selecting “Corrected Claim” and attach to the corrected claim. Submit the claim and completed Provider Dispute Form to the claims mailing address on the back of the member's ID card.

- Institutional claims UB-04 or 837 Institutional claims: Submit with the third digit of Type of Bill as '7' to indicate Frequency code 7. Resubmit all original lines and charges as well as the corrected or additional information using bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. Complete the Provider Dispute Form selecting “Corrected Claim” and attach to the corrected claim. Submit the claim and completed Provider Dispute Form to:

  UnitedHealthcare Community Plan
  PO Box 5220
  Kingston, NY 12402–5220

4.7 Non-payment of Co-payment

Providers may not refuse to deliver covered services to a member because of the member’s failure or inability to make his copay. See TennCare Rules 1200-13-13-.05 and 1200-13-14-04. For more information regarding member cost-sharing, see Chapter IV-C of this Manual.

4.8 Coordination of Benefits

Coordination of Benefits (COB) is designed to avoid duplicate payment for covered services. COB is applied whenever the member covered by UHCCP is also eligible for health insurance benefits through another insurance company. UHCCP recommends the co-payment not be collected until the second payer has paid the claim in order to prevent a possible overpayment.

The Contractor Risk Agreement between UHCCP and the State of Tennessee states: “the TennCare program shall be the payer of last resort for all medical services”. Therefore, if the member is eligible for services or benefits under a group health benefit plan, coverage under that plan will be primary to the TennCare plan.

Contracting Provider agrees to cooperate with UHCCP toward the effective implementation of COB procedures, including identification of services and individuals for which there may be a financially responsible party other than UHCCP, and assist in efforts to coordinate payments with those parties.

How to file:

- When UHCCP is primary, submit directly to us.
- When UHCCP is secondary, submit to primary carrier first, then, submit the Explanation of Benefits ("EOB") with the claim to UHCCP for consideration. EOBs can be submitted to UHCCP electronically. Refer to “Claims Submission Rules” in this Manual.

(Important Notice: As the Tennessee state Medicaid plan, TennCare is always the payer of last resort.)

1.23.15
4.9 Reclamation

Reclamation refers to situations where UHCCP or TennCare has recovered a payment that was made on a claim that should have been submitted to an enrollee’s third party insurance prior to being submitted to UHCCP or TennCare. In some cases, providers who seek payment from third party insurance after reclamation has taken place may have their claims denied by the third party insurance as being duplicate claims. When this happens, these providers may be eligible for a refund from UHCCP or TennCare for payments that have been reclaimed.

If TennCare has recovered the payment in question, providers wishing to receive a refund should complete the Medicaid Reclamation Claim Provider Refund request form located at: http://tn.gov/assets/entities/tenncare/attachments/medicaidreclamation.pdf

If UHCCP has recovered the payment in question, providers can request to have an inquiry started to research their issue as it relates to the Tennessee Reclamation process by either calling 800-727-6735 or faxing the information to 248-733-6019. Providers should have the following information available when they call, or included if they fax in a request where another carrier is involved.

1. EOB on hand or included from the other Carrier
2. The name of the other Carrier
3. Date of the check issued by the other carrier
4. Dollar amount of the check submitted by the other carrier

Once complete information is received, an inquiry will be submitted and research will be conducted to verify the request and determine if payment is due back to the provider. A contact name and phone number shall be included on all faxes in case additional information is needed in order to make the proper determination.

4.10 Interest Payments

Care Providers will not be entitled to interest for underpayments or in the event that UHCCP fails to meet prompt pay standards.

5. Medicare TennCare Dual Eligibility

Medicare co-payments and coinsurance are not covered by UHCCP and the cost of such services shall not be the responsibility of UHCCP. However, UHCCP will pay for all medical services that are covered by TennCare and are not covered by Medicare.

If a member has Medicare benefits, please make your initial claim submission to the Medicare intermediary or the Medicare HMO, as appropriate. If UHCCP receives the claim and a determination is made that Medicare is the primary carrier, the claim will be returned to you with a letter of explanation to the service physician for Medicare submission. Medicare co-payments and co-insurance may be the responsibility of the Bureau of TennCare, or of the individual TennCare member as explained below. Please check the member ID card, contact UHCCP Customer Service, or contact the member.

5.1 Claims Submission for TennCare Medicaid/Medicare Members

Claims filed electronically for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed to Medicare for primary payment. Traditional Medicare should crossover to the Bureau of TennCare for Medicare co-insurance amounts. If the claim is denied for non-covered benefit by Medicare and is covered by the TennCare benefit plan, then attach the EOB to the claim and submit to UHCCP.

Paper claims filed for Medicare/Medicaid dual eligible members (Eligibility Class 17) should be filed with Medicare for primary payment. After Medicare pays primary, the provider must file the paper claim with the EOB to the Bureau of TennCare for reimbursement of Medicare coinsurance amounts.
5.2 Claims Submission for TennCare Standard/Medicare Members (Not Medicaid Eligible)

The Bureau of TennCare and UHCCP are not responsible for copayments and coinsurance for TennCare Standard members who also have Medicare (TennCare Standard/Medicare dual eligibility). These charges are the responsibility of the member and shall be billed directly to the member after Medicare pays as the primary insurance.

If the claim is denied by Medicare as a non-covered benefit and the service is covered by the TennCare benefit plan, the provider should attach the Explanation of Benefits to the claim and submit to UHCCP.

Remember, the Bureau of TennCare does not pay Medicare copayments and coinsurance for TennCare Standard/Medicare dual members; therefore, do not submit such charges to the Bureau of TennCare for payment.

6. Timely Filing Guidelines and Late Criteria

Timely filing improves cash flow for your office. It enables UHCCP to settle fund accounts accurately and to intervene earlier in cases requiring care management to improve patient outcomes. TennCare claims for services must be submitted by 120 days from the date of service, or the claim will be denied for timely filing.

If a member is retroactively enrolled, the 120 days begins at the time TennCare notifies UHCCP of a member’s eligibility.

If UHCCP receives a claim and it requires additional information in order to be processed and paid, the claim will be denied with a request for the additional information. In order to avoid denial for timely filing, you must refile the claim within 120 days from the date of service or 60 days of the UHCCP denial of the claim, whichever is later.

Should a member have primary coverage, the 120 day period begins on the date of the primary EOB. If UHCCP is the secondary insurance carrier, then claims must be submitted and received within 120 days from the date on the primary insurance carrier’s EOB and/or EOMB. Secondary claim submissions can be submitted electronically or with a copy of the primary health payer’s Remittance.

See Chapter VI, Section A-4.8 for COB rules regarding secondary claims submission. If you first submitted a claim to a different payer, you have 120 days from receipt of the denial from that payer to submit the claim to UHCCP for payment. A copy of the denial must be included with the claim submission if more than 120 days has elapsed from the date of service. Please note: an EOB from the other payer must be submitted with every claim but the denial must be submitted if you are submitting to UHCCP more than 120 days after service. In the event UHCCP paid incorrectly, resubmission of billing must occur within 120 days of the date of service or the date of UHCCP payment, whichever is later.

If a claim has been denied for timely filing the following are acceptable forms of documentation for payment reconsideration:

- EOB or EOMB from primary health payer dated within 120 days of claim submission to UHCCP.
• Confirmation of denial from the primary payer within 120 days of claims submission to UHCCP.

• Copy of billing statement to member showing dates of bills or provision of member’s health plan insurance information so that payment can be coordinated

• Documentation proving what may have contributed to the filing delay.

• Electronic Report that states UHCCP has accepted the claim. Computer-generated activity report that shows the date that an electronic claim was originally submitted UHCCP (an acceptable report must contain: member name or identification number, date of service, indication that original claim was submitted electronically).

The following are not acceptable forms of documentation for timely filing payment reconsideration:

• Screen prints showing dates of a claim previously submitted to UHCCP.

• CMS or UB form with “print” date located in Box 31 or Box 86, respectively.

• Electronic report stating UHCCP has rejected the claim.

**B. General Billing Information**

1. **CMS-1500 and UB-04 Health Insurance Form**

   1.1 **Reimbursement Policy**

   UHCCP performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources. Please refer to the reimbursement policies as detailed on the UnitedHealthcare Community Plan Provider Portal for specific information regarding these Program Integrity activities. Unless otherwise communicated, we follow CMS or State Regulatory guidelines for reimbursement policies.

   1.2 **iCES Clearinghouse from Ingenix**

   UnitedHealthcare Community Plan utilizes iCES (INGENIX Claim Edit System clearinghouse), which is owned and maintained by Ingenix. iCES is a clinical edit system application that analyzes healthcare claims based on business rules designed to automate UHCCP reimbursement policy and industry standard coding practices. Claims are analyzed prior to payment to validate billings in order to minimize inaccurate claim payments.

2. **UnitedHealthcare Community Plan Reimbursement Policies**

   UHCCP has Reimbursement Policies that are utilized when paying claims. You should be familiar with these policies as it may be helpful in your billing practices. The UHCCP Reimbursement Policies are reviewed regularly to ensure they are current accurate. The most current policies are always available on the provider website at: http://www.uhcommunityplan.com/health-professionals/TN/reimbursement-policy

   - Add On Policy
   - After Hours Policy
   - Age and Gender Policy
   - Anesthesia Policy
   - Assistant Surgery Policy Audiologic/
   - Vestibular Function Testing B Bundle
   - Codes Policy
   - Bilateral Procedure Policy
Care Plan Oversight Policy
CCI Editing Policy
Clinical Diagnostic Labs Policy
Co-Surgeon Team Surgeon Policy
Contrast and Radiopharmaceutical Materials Policy
Denied Drug Code Policy
Discontinued Procedure Policy
DME Policy
Facility Emergency Room Reimbursement Policy
From-To Date Policy
Global Days Policy
Increased Procedural Services Policy
Injection and Infusion Services Policy
Injection into Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel Policy
Laboratory Radiology Policy
Microsurgery Policy
Maximum Combined Frequency Per Day Policy
Moderate Sedation Policy
Modifier Reference Policy
Multiple Procedure Policy
NDC Requirement
New Patient Policy
Non Covered Codes Policy
Observation Care Evaluation and Management Policy
Once in a Lifetime Procedure Policy
Orencia Policy
Orthotics Policy
Otoacoustic Emissions Testing Policy
Physical Medicine and Rehabilitation Policy: Maximum Combined Frequency Per Day
Physical Medicine and Rehabilitation Policy: PT, OT and Evaluation Management
Physical Medicine and Rehabilitation Policy: Speech Therapy
Physical Medicine and Rehabilitation Policy: Supervised Modalities
Physician Emergency Room Policy
Procedure to Modifier Policy
Professional/Technical Component Policy
Prolonged Services Policy
Radiology Multiple Imaging Policy
RAST Test Policy
Rebundling Policy
Reduced Services Policy
Registered Dietician and Home Health Policy
Rituxin Policy
Robotic Assisted Surgery Policy
Same Day/Service Policy
Split Surgical Package Policy
C. Provider Dispute Processes

In the event you have general questions or feel UHCCP has not met its obligations of the provider agreement, Provider Manual, CRA or any other State of Tennessee regulatory authority, you have several options to resolve the concerns or disputes. You should always start with an inquiry to your Provider Advocate. If you are not sure who your Provider Advocate is, please use the contact information specified in the Key Contact Information located in Chapter II, Section C. In addition to utilizing your Provider Advocate, the following sections explain other methods to address claims issues and provider complaints.

1. Provider Disputes (Reconsideration Requests)

If you believe you were underpaid by us, you may request reconsideration within 365 days of a partially or totally denied claim by requesting a Claim Reconsideration (Provider Dispute). The quickest way to submit a Claim Reconsideration request is directly through the secure provider portal.

Go to Community Plan Online, select Claims > Billing Services > Adjustments. Please identify the specific claims in “paid” or “denied” status which you believe should be adjusted and give a description of the requested adjustment.

- If written documentation, such as proof of timely filing, is needed you must use the Provider Dispute (Claim Reconsideration Request) Form found in the Forms Appendix or at: http://www.uhccommunityplan.com/assets/TN-ProviderDisputeFormMarch2011.pdf.

If you are submitting a Claim Reconsideration Request Form for a claim which was denied because filing was not timely:

- Electronic claims - include confirmation that UHCCP or one of its affiliates received and accepted your claim.
- Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.

Note: All proof of timely filing must also include documentation that the claim is for the correct member and the correct visit.

Alternatively, you can call UHCCP Customer service at 800-690-1606 to request an adjustment for issues which do not require written documentation.

If you have issues involving 20 or more paid or denied claims, you can aggregate these claims and submit for research and review directly through Community Plan Online and choose Claims > Billing Services > Adjustments.
2. Provider Independent Review Process

Providers may file a request with the Commissioner of Commerce and Insurance for an independent review pursuant to the TennCare Provider Independent Review of Disputed Claims process, which shall be available to Providers to resolve claims denied in whole or in part by UHCCP, or when a previously allowed claim that has been subsequently partially or totally denied by UHCCP, as provided in T.C.A. 56-32-126. It is understood that in the event Providers file such a request with the Commissioner of Commerce and Insurance for Independent Review, such dispute shall be governed by T.C.A. 56-32-126(b).

Sample copies of the Request to Commissioner of Commerce & Insurance for Independent Review of Disputed TennCare Claim form, instructions for completing the form, and frequently asked questions developed by the State of Tennessee Department of Commerce and Insurance can be obtained on the state’s website at https://www.tn.gov/commerce/article/tncoversight-independent-review-process.

You may also call the State of Tennessee at 615-741-2677.

Provider Complaints and Provider Requests for Reconsideration are handled within 60 days by UHCCP. Please call UHCCP at 800-690-1606 to initiate any requests for resolution of complaints or Requests for Reconsideration may be mailed to:

UnitedHealthcare Community Plan
Attn: Provider Disputes
PO Box 5220,
Kingston, NY 12402-5220

D. Home Health and Private Duty Nursing Benefits and Billing Requirements

All Home Health ("HH") and Private Duty Nursing ("PDN") services require prior authorization. Each member will require a designated care plan and supporting physician orders that demonstrate the member’s clinical needs, specific amount of clinical services (nursing and aide) required, and authorizations will require specificity to the level of services authorized. The authorized codes and units will be done in a manner consistent with the billing and coding guidelines below:

- HH benefit will be accumulated based on Revenue and HCPC codes billed and appropriate increment of time.
- Benefit week is defined as Monday - Sunday.
- Billing must occur on one claim per defined benefit week per member.
- If second claim is billed for same week, claim will be denied.
- Must bill each day and service as a single line on the claim.
- Private Duty Nursing will be approved as medically necessary for those that meet the necessary qualifications. Revenue Code HCPC Code Increment of time Skilled Nursing/Visit 551 G0154 15 minute. Limit to four 15 minute units or 1 total hour OR Skilled Nursing/Hours 552 S9123 1 hour S9124 1 hour.
• If visit is an hour or less G0154 should be used, if more than 1 hour ONLY S9123/S9124 should be used for entire visit.

**Skilled nursing benefit:**

• 27 hours per week maximum unless qualified for Level II Nursing Home with PAE, then 30 hours per week maximum

• Preauthorization must identify if member has PAE

• Limit of only 1 visit up to 8 hours per day. Revenue Code HCPC Code Increment of time Home Health Aide/Visit 571 G0156 15 minute. Limit to 4 15 minute units or 1 total hour OR Home Health Aide/Hour 572 S9122 1 hour

• If visit is an hour or less G0156 should be used, if more than 1 hour ONLY S9122 should be used for entire visit

**Home Health Aide benefit:**

• Up to 2 home health aide visits each day, limit of 8 hours each day

• 35 hours per week maximum unless qualified for Level II Nursing Home with PAE, then 40 hours per week maximum

**If member is receiving both skilled nursing and home health combined:**

• Benefit is limited to combined total of 8 hours each day

• Benefit is limited to combined total of 35 hours per week

• If member is qualified for Level II Nursing Home with PAE the combined care benefit limit each week is 40 hours

• Private Duty Nursing is a benefit for members under 21 and those members over 21 that are ventilator dependent or have a functioning tracheotomy and need certain other kinds of nursing care Private Duty Nursing 589 T1000 15 minute

**E. Hospital Observation Bed Billing Requirements**

These billing guidelines should be used to determine whether a member requires admission or other treatment.

• Outpatient observation is limited to up to 48 hours for physical health observation, and up to 23 hours for behavioral health observation.

• When a member is admitted after an outpatient observation, UHCCP will consider the date the member entered outpatient observation as the first day of the inpatient admission.
• Billing Guidelines

— Use observation revenue codes of 760, 761, or 762.

— Place number of hours in observation in the unit field. (1 hour = 1 unit)

Bill for observation even if the member is later admitted. You may bill observation and inpatient on the same claim. Observation day(s) will be considered the first day(s) of the inpatient admission. The observation day(s) will be part of the inpatient reimbursement.

F. Hospice

Effective April 1, 2007, Hospice services shall be provided and reimbursed in accordance with state and federal requirements, including but not limited to the following:

• Rates shall be no less than the federally established Medicaid hospice rates (updated each federal fiscal year (FFY)), adjusted by area wage adjustments for the categories described by CMS;

• The rates described above shall be subject to the annual cap for Medicaid Hospice rates as provided annually by CMS; and

• If a Medicaid hospice patient resides in a nursing facility (NF), the CONTRACTOR shall pay an amount equal to at least 95 percent of the Tennessee Comptroller prevailing NF room and board rate to the hospice provider (not subject to the annual cap for Medicaid Hospice rates).

Hospice claims shall be submitted by the provider in accordance with all applicable Medicare and UHCCP billing guidelines.
G. TennCare Kids Billing

1. Billing for TennCare Kids (Early Periodic Screening, Diagnosis, and Treatment “EPSDT”) Services

TennCare Kids is integral to providing services to TennCare children (under the age of 21). These services are tracked through chart review and by the encounter data gathered from claim submission. Specific codes are used to analyze encounter data and determine screening rates. All TennCare Kids services which are both covered and medically necessary are paid per your contracted fee schedule. There is not a prior authorization required for TennCare Kids screening services provided by a participating UHCCP provider. Please ensure that claims for TennCare Kids services include codes for all services rendered, including Immunization Administration, Vaccines, Vision and Hearing Screenings, etc.

2. TennCare Kids (EPSDT) Procedure and Diagnosis Code List*

2.1 Well Child and Preventive Services Codes

- CPT-4 Preventive Medicine Services Codes
  - 99381-99385
  - 99391-99395
  - 99460-99462

- ICD-10 Well child diagnosis codes:
  - V20-V20.2, V 20.3, V20.31 and V20.32
  - V70.0
  - V70.3-V70.9

- CPT-4 Evaluation and Management Office or Other Outpatient Services Codes filed with Preventative Diagnosis:
  - 99201-99205
  - 99211-99215

- Validated Development Screening
  Test:—  96110
2.2 CPT Hearing

- 92551 Screening test, pure tone, air only
- 92552 Pure tone audiometry, threshold, air only
- 92583 Select picture audiometry
- 92586 Auditory evoked potential for evoked response audiometry, limited
- 92587 Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products.)


2.3 Vision

- 99173 Quantitative bilateral visual acuity exam, e.g., Snellen chart on the wall
- 99174 Ocular photoscreening, with interpretation and report, bilateral (Do not report 99174 in conjunction with 99173.)


2.4 CPT Modifiers

- 25 Significant separately identifiable evaluation and management service by same physician on same day of procedure of other service
- 90 Reference lab performed procedure, e.g. sending out a blood lead test
- 91 Repeat lab test on same visit, e.g. confirmatory hemoglobin

Note: Please refer to the CPT book for a complete list of modifiers

2.5 Multiple Services on Same Visit

Certain Evaluation and Management (E&M) Office services (99201 through 99205, 99212 through 99215) may be performed on the same day by the same provider as a Preventive Medicine (“PM”) (99381 through 99385, 99391 through 99395) service. If the E&M Office or Other Outpatient service is both separate and significant from the Preventive Medicine service, then it may be reported in addition to the Preventive Medicine service by the attaching a -25 modifier to the E&M Office or Other Outpatient service performed for that separate problem. The -25 is not attached to the Preventive Medicine service.

- Example- 9 month old who requires a separate E&M office service for bronchiolitis on the same day as the Preventive Medicine service could be billed as follows:
  
  CPT ICD-10CM
At times it may be necessary to perform procedures (spirometry, aerosol treatment, etc.) in addition to an E&M Office or Other Outpatient service. In this case the services are reported by attaching a -25 modifier to the E&M Office or Other Outpatient service.

- Example- 9 month old who receives an E&M Office or other Outpatient Service for bronchiolitis. An aerosol treatment is given as part of the visit. It could be billed as follows:

  CPT ICD-10
  99213-25 466.1
  94640 466.1

Note: Documentation may be requested when E&M and PM services are rendered simultaneously.

3. Vaccine for Children (VFC) Billing

Vaccines that are included as part of the VFC program and administered to UHCCP members will not be reimbursed, except as directed by the Bureau of TennCare during times of a vaccine shortage affecting the supply of any VFC-included vaccines. Only in this situation will UHCCP pay for a VFC-included vaccine which was purchased at the provider's expense and given to a UHCCP member. Vaccines so designated by the TennCare Bureau will be paid according to your contracted fee schedule with UHCCP. All vaccines given to UHCCP members should be submitted for claims payment using the CPT code for the individual vaccines the provider administered. However, please submit each VFC supplied vaccine with a zero dollar charge so that vaccines can be tracked for reporting purposes for quality measurement with the Bureau of TennCare and NCQA for HEDIS measurement. UHCCP does pay a vaccine administration fee for all VFC-included vaccines administered to our members at the reimbursement rate specified in your fee schedule.

Consult the official list of approved Vaccines and Biologicals for the Vaccine For Children's (VFC) Program and other Federal and/or State Regulations supporting this program through The Centers for Disease Control at http://www.cdc.gov/vaccines/programs/vfc/index.html or the State Immunization Program at http://tn.gov/health/section/immunization-program.
As a reminder, if you report 90461 for the administration of additional vaccine components in any combination vaccine, our payment will be $0 in accordance with the December 30, 2010 VFC program guidance from the Tennessee Immunization Program Office.

5. Revenue Codes Which Require CPT or HCPCS Procedure Codes

260 IV Therapy
261 IV Therapy/Infusion Pump
262 IV Therapy/Pharm SVCS
263 IV Therapy/Drug/Supply Devices
264 IV Therapy/Supplies
269 IV Therapy/Other
290 Durable Medical Equipment
291 Durable Medical Equipment
292 Durable Medical Equipment
293 Durable Medical Equipment
300 Laboratory
301 Chemistry
302 Immunology
303 Renal Patient (Home)
304 Non-Routine Dialysis
305 Hematology
306 Bacteriology & Microbiology
307 Lab-Urology
309 Lab-Other
310 Laboratory-Pathological
311 Cytology
312 Histology
320 Lab-Pathology
321 Angiocardiography
322 Arthrography
323 Arteriography
324 Chest X-ray
329 Radiology Other
330 Radiology-Therapeutic
331 Chemo- Inj
332 Chemo-Oral
335 Chemo-IV
339 Radiation/Therapy
340 Nuclear Medicine
341 Diagnostic
342 Therapeutic
350 Ct Scan
351 Head Scan
352 Body Scan
359 Ct Scan
360 Operating Room
361 Minor Surgery
362 Organ Transplant—Other than Kidney
369 Operating/Recovery Room
400 Other Imaging Services
401 Diagnostic Mammography
402 Ultrasound
403 Screening Mammography
404 Positron Emission Tomography
409 Diagnostic Radiology—Other Imaging Services
410 Respiratory Services
412 Inhalation Services
419 Other Respiratory Services
460 Pulmonary Function—Diagnostic
469 Other Pulmonary Function
470 Audiology
471 Audiology/DX
472 Audiology/RX
480 Cardiology
481 Cardiac Cath Lab
482 Stress Test
483 Echocardiography
489 Other Cardiology
490 Op Clinic/Surgi Ctr
499 OPClinic/Surgi Ctr
551 Skilled Nursing/Visit
552 Skilled Nursing/Hour
571 Home Health Aide/Visit
572 Home Health Aide/Hour
589 Private Duty Nursing
610 MRI
611 Brain
612 Spinal Cord
614 Diag/Rad/MRI
615 Dia/Rad/MRA Head and Neck
616 Diag/Rad/M RA/Lower
618 Diagnostic/Rad/MRT Other
619 Diagnostic/Rad/MRT Other
623 Surgical Dressing
624 FDA Investigation Devices
730 EKG/ECG
731 Holter Monitor
732 Telemetry
739 Other/EFG/ECG
740 EEG
750 Diag/Rad-Gastrointest Svcs
790 Lithotripsy
799 Lithotripsy
921 Peri Vascular Lab
922 EMG
923 PAP
924 Durable Medical Equipment
925 Allergy Test
929 Additional DX Services
940 Other RX Services
941 Recreational RX
942 Nutritional Counseling
949 Addnl RX Svcs

- Additional Revenue Code Guidelines
  - If 270 is submitted by itself on an outpatient claim, UHCCP requires a code or description.
  - 274 Description or Valid HCPC is required to be considered for payment.
  - 250 through 259 requires an itemized statement if charges are over $1000.00

Please Note: All Revenue Codes need the exact dates if span dates.

**H. Locum Tenens Policy**

In instances when a participating provider has a locum tenens covering for a short period of time (less than 60 days), it will be the participating provider’s responsibility to ensure appropriate licensure, malpractice insurance and other pertinent information is validated prior to allowing the locum tenens to treat members. Claims should be submitted under the participating physician’s name, Tax ID and suffix.

**I. Psychological Assistants and Behavioral Health Interns**

Attending physicians must provide services directly for all UHCCP members. In general, attending physicians may not submit claims in their name for treatment or psycho diagnostic services that were provided by a resident, psychological assistant or intern.

**J. Allied Health Professional/Mid-level Practitioner Network Participation and Billing Requirements**

UHCCP requires “Allied Health Professionals/Mid-level Practitioners” (e.g., Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists) to be credentialed and contracted before providing services to TennCare members. Additionally, Allied Health Professionals/Mid-level Practitioners must be supervised by physicians who are current UHCCP participating providers and who are practicing in the same area of medicine as the Allied Health Professional/Mid-level Practitioner. Failure to comply with this requirement may result in immediate contract termination.
K. Records and Patient Information for Claims and Medical Management

Medical records and patient information shall be supplied at the request of UHCCP or appropriate regulatory agencies as required for claims payment and medical management. The provider is not allowed to charge UHCCP or the member for copies of medical records provided for claims payment or medical management. The provider may charge the member for records provided at the member’s request, in accordance with Tennessee Code Annotated 63-2-101 & 63-2-102.

Providers are not allowed to charge UHCCP or the member for records provided when a member moves from one PCP to another.

L. Encounter Data Collection

All data required for encounter collection and reporting is drawn from submitted claims. Should your office have a capitation arrangement with UHCCP, encounters must be submitted with the same level of required information as fee for service claims.
VII. Primary Care Providers

A. Member Assignment to a Primary Care Provider

Members are automatically assigned to a Primary Care Provider (PCP) based on the member’s geographical location, age and gender.

1. Access to the PCP Panel Roster

PCPs can view his/her roster of assigned members by accessing Community Plan Online (www.uhccommunityplan.com > Health Professionals>Tennessee>Claims and Member Information, login to the secured portal), select Patient > Patient Services and select the PCP Panel Report on the right-hand side of the screen. Providers can search for an individual member by UHCCP Member ID Number or Member Name, Last Name and Date of Birth. Searching by Member ID Number is the fastest and most accurate search method. If you have any questions or problems accessing your panel roster, you may contact Customer Service at 800-690-1606.

B. PCP Change Request

If a member arrives in your office to receive covered services and you are not the PCP listed on the Member ID Card, a request can be made to UHCCP to change the PCP assignment. Once you or the member has completed the PCP Change Request form, fax to 888-205-9851. A new Member ID Card with the updated PCP information will be mailed to the member address on record. The PCP Change Request Form can be found in the Forms Appendix of this Manual or on the provider website at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-PanelStatusChangeRequestForm.pdf.

C. The Role of a PCP

UHCCP encourages prevention and early treatment of illness for its members and is committed to creating and maintaining relationships with its network providers, both medical and behavioral health. UHCCP has established and made available assessment, treatment planning, and documentation guidelines and has adopted practice guidelines to assist the providers. These assessment guidelines recognize the importance of a thorough assessment to screen for medical disorders, behavioral health disorders and substance use disorders.

The PCP plays a vital role as a physician case manager in the UHCCP system by improving health care delivery in four critical areas: access, coordination, continuity and prevention.

The PCP is responsible for the provision of initial and basic care acting as the medical home for all assigned members. A medical home is primary physical and behavioral care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. When necessary, the PCP is responsible for making referrals for specialty and ancillary care. The PCP may be required to submit clinical and/or other documentation when the member is referred to a non-participating provider. The PCP should be aware of and assist in coordinating all care delivered to members. The PCP must provide 24-hour/7-day coverage and back up coverage when he or she is not available.
In 2015, UnitedHealthcare will launch Lock In Your Doc to encourage members to establish an ongoing relationship with their primary care physician (PCP).

If you are a PCP, the program requires you to only provide services to members assigned to you or your medical group/tax ID number (TIN). Starting Aug. 1, 2015, UnitedHealthcare Community Plan may not pay for services rendered by a care provider not assigned to that member.

To help you prepare for the program, we will add a new PCP assignment explanation code to the provider remittance advice (PRA) starting Jan. 1, 2015. The new code will help you identify which members you provide services to who are not assigned to you or your medical group/TIN: Services not provided by network/primary care providers (242). Covered only when performed by the primary treating physician or the designee (N450).

Please be sure to check the member’s UnitedHealthcare Community Plan member ID card or visit UHCCommunityPlan.com to view your PCP roster and confirm you are the assigned PCP before providing services. Members can request to change their PCP assignment by calling 800-690-1606.

1. Expectations of the PCP

Offer access to office visits on a timely basis

- Conduct a baseline examination during the member’s first appointment
- Treat general health care needs of all assigned members
- Provide all TennCare Kids screenings and services as required for members under 21 years of age
- Screen members for behavioral health problems
- Refer to participating specialists for health problems not managed by the PCP. The PCP completes a referral form or prescription and assists the member in making an appointment. A complete listing of participating providers is located online at http://www.uhcommunityplan.com/plan/details/TN/3/All%20Plans/find-a-provider.
- Refer members, as appropriate, for Early Intervention Services.
- Document the reason for a specialist referral and the outcome of the specialist intervention in the member’s medical record.
- Coordinate each member’s overall course of care.
- Be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating PCP
- Educate members about appropriate use of emergency services
- Discuss available treatment options and alternative courses of care with member

2. Coordination With Other Service Providers

The PCP is the point of entry into the health care delivery system. With the exception of services which allow for self referral such as certain OB/Gyn services, emergencies, and out-of-area urgent care, the PCP shall make any necessary referrals for specialty and ancillary health care services. Coordination of care between physical, mental health, substance abuse and long term services and supports (CHOICES) providers is important for improved outcomes in treatment. Providers should evaluate individuals in their care for other health care needs and refer as appropriate. If referral information to other providers is needed, providers may contact Customer Service at 800-690-1606.
Your office may contact dental, vision, non-emergent transportation, pharmacy, and mental health/substance abuse services directly on behalf of the member, or you may contact UHCCP for assistance with coordination, as needed. Contact information for other covered services is located in the Key Contact Information section of the manual.

UHCCP expects PCPs to communicate the reason for the referral to the specialists by use of a prescription or letter, and to note this in the patient's medical record. Referrals to other providers should include, at a minimum, the individual's identifying information, the reason(s) for the referral, medication(s) the individual is currently being prescribed, diagnosis(es), current course of treatment, and any other pertinent information deemed appropriate by the referring provider. All specialists are expected to communicate to the PCP any significant findings and recommendations for continuing care. A specialist may not refer the member directly to another specialist.

**2.1 Coordination for Children – TennCare Kids Services**

Coordination of services for children needs to be handled in accordance with TennCare Kids requirements. All referrals should be documented in the child's chart. Each quarter, a list of participating specialists will be mailed to the offices of primary care providers to aid the referral process.

If you need assistance arranging for transportation, referrals to specialists, requests for Individual Education Plans (IEPs), or other services for children, please contact UHCCP Case Management at 800-690-1606.
VIII. Preventive Care

UHCCP encourages members to obtain preventive services with a network provider in a Primary Care Medical Home.

When a child turns two, 12 and 18 months old, they receive a reminder postcard to make an appointment for any necessary immunizations. Children ages 11 to 12 should have their immunization status reviewed. At this age, they will need to receive immunizations based on their immunization status. Immunizations should be reviewed and administered at appropriate ages, or as needed. Consult the current Advisory Committee on Immunizations Practices (ACIP) recommended immunization schedule at http://www.cdc.gov/vaccines/schedules/index.html.

Access, receipt, and tracking of immunizations are high priorities for UHCCP and the State of Tennessee. Continued cooperation in serving TennCare members is appreciated.

Guidelines address patient safety by communicating evidence-based guidelines to physicians and members. Preventive guidelines can help to reduce unnecessary screening tests not supported by medical evidence and reduce the potential for false positive test results and sequentially adverse medical events.

A. Preventative Guidelines

UHCCP’s goal is to partner with providers to ensure that members receive preventive care. UHCCP has adopted the recommendations contained in U.S. Preventive Services Task Force’s Guide to Clinical Preventive Services and the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. For more information about the TennCare Kids program, please refer to Chapter XIII TennCare Kids.

UHCCP endorses and monitors the practice of preventive health standards recommended by recognized medical and professional organizations including, but not limited to:


• Department of Health and Human Services – Centers for Disease Control and Prevention CDC Recommended Adult Immunization Schedule http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule.pdf

• Department of Health and Human Services – Centers for Disease Control and Prevention CDC Recommended Immunization Schedule for Persons Aged 0-18 Years http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html

• Bright Futures/ American Academy of Pediatrics http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

Review of guidelines occurs on an annual basis. Programs encouraging the use of identified preventative services have been established. Components of the programs may include member reminders, member and provider education, partnering with community agencies, and working with physicians to identify members who have not received the service.
B. Preventative Programs

Preventative Programs include:

- Well visits for children, adolescents, and adults
- Childhood Immunizations
- Adolescent Immunizations
- Healthy Nutrition for prevention of childhood obesity
- Smoking Cessation Assistance
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Flu and Pneumonia immunizations in select high risk populations
- Immunizations for adults and pregnant women
- TennCare Kids (EPSDT): Early, Periodic, Screening, Diagnosis, and Treatment for TennCare members
- Colorectal Screening
- Prostate Screening
- Alcohol Misuse
- Depression
IX. Utilization Management

**Goal:** The goal of the Utilization Management (UM) Program is to assure that:

- Care is provided in the right setting, for the right patient, at the right time
- Care is provided by the most appropriate provider

To accomplish this goal, the processes must be sound and the application of the processes must be consistent. Therefore, UHCCP:

- Uses care management and continuums of care principles.
- Uses guidelines for care management.
- Tracks medical utilization data.
- Follows guidelines established by all applicable regulatory and accrediting bodies, including, CMS, TennCare, and the National Committee for Quality Assurance (NCQA)
- Evaluates annually the effectiveness of the Medical Management Programs.
- Reports outcomes and customer satisfaction using the standard measures of Medicare, HEDIS and CAHPS (Consumer Assessment of Health Care Providers and Systems).

As a contracted provider, you agree to comply with the UHCCP’s medical policies, Quality Improvement and Medical Management programs, and ongoing Utilization Review Program.

Only qualified physicians may issue UM denials. Only registered pharmacists or physicians may deny payment authorization for medications that require prior authorization.

Utilization management decisions are based on the appropriateness of the care and services as determined by national guidelines for best practice while also considering individual patient needs. UHCCP does not compensate or reward UM reviewers for denials of coverage. Nor do UM reviewers receive financial incentives to influence UM decisions. UHCCP seeks to avoid under and over utilization of medical services.

Some services, which providers may recommend, are not covered as part of the TennCare benefit package. If you have questions about what services or treatments are covered contact Customer Service at 800-690-1606.

**A. Program Overview**

1. **Components of the Utilization Management Program**

   1.1 **Out of Network Authorization**

   A documented process for authorizing out-of-network care at an in-network level of benefits as determined by the member’s benefit plan.

   1.2 **Prior Authorization**

   A documented process for authorizing procedures and/or hospital admissions using established review criteria.
1.3 Inpatient Review
A process for reviewing the appropriateness of admission to the hospital and ongoing inpatient care.

1.4 Ambulatory Review
A process for evaluating the appropriateness of services performed in the ambulatory setting.

1.5 Confidentiality of Physician-specific Information
Physician-specific information gathered during the UM processes is confidential and will not be released to the public or the member without written consent of the physician.

1.6 Organization and Responsibility
The development and continued improvement of the Utilization Management Program is the responsibility of the Health Services team. Responsibility for ongoing monitoring of the application of the Utilization Management Program lies with the Chief Medical Officer.

2. Authority for Medical Management Decisions
Criteria exist which may allow a nurse reviewer or Behavioral Health Care Advocate to approve payment for a treatment, physician or location of treatment. The ultimate authority, however, for any denial of a request for payment lies with the Chief Medical Officer through the Physician Medical Review Process.

The attending physician has the ultimate authority for the medical care of the patient. The medical management process does not override this responsibility. If there is disagreement regarding the appropriate intensity or location of care, the attending physician shall be allowed to care for the patient without any encumbrances from the medical management process.

3. Ensuring Appropriate Service and Coverage for Members (Behavioral Health)
UHCCP facilitates the delivery of appropriate behavioral health care and uses a variety of database mechanisms to monitor potential under-and over-utilization of services.

Care management decisions are based on the appropriateness of care as defined by the Behavioral Health Level of Care Guidelines or American Society of Addiction Medicine (ASAM) Guidelines as well as Clinical Best Practice Guidelines in which are in accordance with the TennCare benefit plan and applicable state and federal laws. These guidelines can be found on the UHCCP’s provider website at http://www.uhccommunityplan.com/health-professionals/TN/provider-information or by contacting Customer Service at 800-690-1606. Providers should become knowledgeable of these documents to ensure services are being rendered in accordance with the TennCare benefit plan and as medically necessary.

The UHCCP Behavioral Health Level of Care Guidelines (LOCGs) were developed to assist providers in understanding requirements for a service to be considered medically necessary and to produce optimal clinical outcomes and consistency in the authorization of care by the clinical and medical staff. UHCCP Behavioral Health Level of Care Guidelines are subject to change. Any changes will be posted on the UHCCP provider website at http://www.uhccommunityplan.com/health-professionals/TN/provider-information. Providers are responsible for monitoring and adhering to the Level of Care Guidelines and will be notified of changes per the terms and conditions of individual provider agreements.
UHCCP does not reward individuals conducting utilization review for issuing denials of coverage of services. We do not encourage or provide incentives for UHCCP staff or contractors to make decisions that result in under utilization of behavioral health care services.

4. Technology Review Process

UHCCP has a Technology Assessment Process which evaluates and addresses the safety, efficacy, and appropriateness of emerging and new medical/behavioral technologies, as well as keeps pace with changes to existing medical/behavioral health technology. This evaluation process allows UHCCP to make recommendations regarding the medical/behavioral technologies use for potential inclusion in the benefit plan. This evaluation process includes the review of medical/behavioral health procedures, devices and selected pharmaceuticals. If you have a technology that you would like to have reviewed, please contact UHCCP at 800-690-1606.

5. Advanced Directive

The patient Self-determination Act requires that HMO patient records (charts) note whether or not an advance directive has been made. If the patient has given the physician a copy, it should be filed in the patient’s chart. A notation that the physician has addressed advanced directives should be present on adult (age 18 and older) patient charts.

Advanced directives are also available for members to specify their desires for behavioral health services. These directives are called Declarations for Mental Health Treatment and the form for use is located in the Forms Appendix of this Manual. Additional information for providers is available by calling the Tennessee Department of Mental Health and Developmental Disabilities’ Office of Consumer Affairs at 800-560-5767 or at their website: http://tn.gov/mental/legalCounsel/olc.html.

6. Out-of-Network

TennCare members must receive routine, preventive, and scheduled care within the contracted provider network. Out of Out-of-network “OON” services are only covered if: an emergency condition exists, or an approved referral has been granted.

- UHCCP processes service requests for treatment authorizations under the direction of the PCP and OON attending physician.

- UHCCP, in conjunction with the PCP and the OON doctor, coordinates member’s transfer back to the in network Service Area when medically feasible as appropriate.

- UHCCP provides out-of-network coverage for urgent or emergent stabilization services. This will include the time he/she is stabilized in the emergency room, prior to admission as an inpatient or discharge from the facility.

- UHCCP also provides coverage for post-stabilization care services. Post-stabilization care services are those that are provided after a member is stabilized in order to maintain the stabilized condition.

- Coverage for out-of-network inpatient services continues only as long as member’s condition prevents transfer to a participating hospital. Transfers should occur within 48 hours of determination of member’s transferability.
B. Timing of Utilization Management Decision

Medical management decisions must be made in a timely manner. UHCCP’s turnaround times are in compliance with TennCare, Federal (including ERISA), and state regulations as well as NCQA standards.

Every attempt will be made to insure that all pre-service, concurrent, and post service authorization decisions are made with practitioners and members notified according to UHCCP’s policy, regulatory, and external requirements.

The final decision concerning admission, referral, and the continued medical management of the patient will be solely the responsibility of the attending practitioner.

1. Physician Responsibility for Adequate Clinical Information

Adequate clinical information must be provided by the requesting provider’s office when making UM requests.

Clinical information provided by the requesting physician is the supporting documentation for whether medical necessity can be justified. The absence of complete and adequate clinical information at the time of request and review results in increased administrative time and work for both the physician office staff as well as for UHCCP reviewing physicians and other health plan staff.

2. Service Definitions

**UHCCP has adopted ERISA and NCQA service definitions.

   a. Pre-Service

   Pre-service authorizations are services requiring approval for payment, either in whole or part, by UHCCP prior to the member receiving services. Example: out of network referrals and procedure prior authorization.

   b. Concurrent Review

   Concurrent service authorizations are services requiring approval for continued authorization of a previously approved, ongoing course of treatment over a period of time or number of treatments. Example: concurrent inpatient, skilled, or rehabilitation review.

   c. Post Service Review

   Review for services already incurred.

   d. Urgent Care

   Request for medical service in which application of the non-urgent review timeframes may in the opinion of a practitioner with knowledge of the member’s medical condition result in severe pain or loss of function.
3. Standard Timeframe Guidelines

Utilization management decisions and notice requirements are developed consistent with applicable state and federal laws and regulations and accreditation standards.

<table>
<thead>
<tr>
<th>Decision Turn Around Time</th>
<th>Practitioner Notification of Approval</th>
<th>Written Practitioner/Member Notification of Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent Pre-service</td>
<td>14 calendar days of receipt of request</td>
<td>Within 14 calendar days of the request</td>
</tr>
<tr>
<td>Urgent/Expeditied Pre-service</td>
<td>72 hours of receipt of request</td>
<td>Within 72 hours of the request</td>
</tr>
<tr>
<td>Urgent Concurrent Review</td>
<td>24 hours of receipt of request</td>
<td>Within 24 hours of the request</td>
</tr>
<tr>
<td>Post-service Decision</td>
<td>30 calendar days of receipt</td>
<td>Within 30 calendar days of the request</td>
</tr>
</tbody>
</table>

C. Prior Authorization

1. Services That Require Prior Authorization and Contact Information

You may also contact Customer Service at 800-690-1606 to request a current list of services that require prior authorization and a list of codes. Further details about prior authorization requirements can be found at UHCCommunityPlan.com > For Health Care Professionals > Tennessee.

<table>
<thead>
<tr>
<th>Service Needed</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health and Substance Abuse - Ambulatory</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>• Mental Health Case Management (Level I Team Approaches Only)</td>
<td>In case of an emergency, call the local Mobile Crisis Line. For Crisis Line Contact information, please refer to Key Contacts Section of this Manual in Chapter II, Section C.</td>
</tr>
<tr>
<td>• Intensive Outpatient (Excluding first 20 visits)</td>
<td></td>
</tr>
<tr>
<td>• Supported Housing</td>
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<tr>
<td>• Psychological Testing</td>
<td></td>
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<tr>
<td>• Applied Behavioral Analysis</td>
<td></td>
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<tr>
<td>• Electro Convulsive Therapy</td>
<td></td>
</tr>
<tr>
<td>Service Needed</td>
<td>Contact Information</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Hospital Services-- Behavioral Health and Substance Abuse</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
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<tr>
<td>• Detoxification</td>
<td></td>
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<tr>
<td>• Rehabilitation</td>
<td></td>
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<tr>
<td>• Partial Hospitalization (excluding first 15 units)</td>
<td></td>
</tr>
<tr>
<td>• Residential Treatment Facility</td>
<td></td>
</tr>
<tr>
<td>*Please note providers are required to submit documentation supporting inpatient psychiatric hospitalization for involuntary admissions the next business day. Involuntary psychiatric hospitalizations do not require a prior authorization. <strong>UHCCP applies medical necessity criteria after the first 24 hours of an involuntary admission per our Contractor Risk Agreement (CRA).</strong> Voluntary psychiatric hospitalizations do require a prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Bariatric Surgery Evaluations and Bariatric Surgery</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Cosmetic and Reconstructive Surgery</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Durable Medical Equipment and Supplies (&gt; $500 Per Item)</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Functional Endoscopic Sinus Surgery</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Home Health Care Services (HHC) • Medication or Infusion • All Other</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Hospice Services - Inpatient and Outpatient</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Hospital Services - Inpatient • Acute (Medical, Surgical, Level 2 through Level 4 Nursery, and Maternity) • Sub-acute, Rehabilitation and SNF</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Hospital Services - Outpatient • Certain outpatient procedures require prior authorization to be performed in an outpatient hospital site of service.</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>MRI, CT, PET Scans, Outpatient Chemotherapy and Nuclear Cardiac</td>
<td>Call eviCore</td>
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<tr>
<td></td>
<td>Call 866-889-8054</td>
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<tr>
<td></td>
<td>Fax 866-889-8061</td>
</tr>
<tr>
<td>Non-Contracted Provider Services (Hospital and Professional)</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Occupational Therapy after the initial evaluation and 6 visits</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Call 866-434-5524</td>
</tr>
<tr>
<td></td>
<td>Fax 866-434-5523</td>
</tr>
<tr>
<td>Prosthetics and Orthotics (&gt; $500 Per Item)</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Skilled Nursing Facility Services</td>
<td>Call 800-690-1606</td>
</tr>
<tr>
<td>Speech Therapy after the initial evaluation</td>
<td>Call 800-690-1606</td>
</tr>
</tbody>
</table>
D. Concurrent Hospital Review Process

The role of the Medical Director is to review for appropriateness of admissions and need for continued stay, as well as the quality of care being provided for those cases referred by a nurse reviewer or behavioral health advocate.

Admissions are usually reviewed on the first working day following admission, using UHCCP’s Level of Care Guidelines, American Society of Addiction Medicine (ASAM) guidelines, Milliman Care Guidelines (“MCG”), and DSM. Each decision is made taking the individual member circumstance into consideration. If an admission or continued stay does not meet criteria outlined in the guidelines and the individual member circumstance, the nurse reviewer or behavioral health advocate will refer the case to the Medical Director. If the Medical Director cannot justify the care, the requestor of services will be notified of decision. Peer to Peer or submission of additional clinical to support medical necessity will be offered.

If the attending wants to speak with the Medical Director, they will be allowed that opportunity within one business day of the request. External Independent Review will be obtained for expert clinical insight into medical necessity decisions if:

- It is determined to be necessary by the UHCCP Medical Director,
- A member requests such review in accordance with applicable state laws.

The ultimate decision regarding medical management of a member is solely the responsibility of the attending physician. An attending physician is never told he/she must discharge a patient, only that the admission/continued stay is not determined to be medically necessary by UHCCP.

1. Hospital Review Process

Concurrent hospital review addresses many aspects of a member’s medical care in the hospital. Nurses/behavioral health care advocates review the hospital record for documentation related to:

- medical necessity supporting the acute inpatient level of care
- potential quality of care concerns
- documented quality of care or service or patient safety issues
- any system issues with care
- healthcare acquired conditions or other Provider preventable conditions
Individual member or physician issues are reviewed on a case by case basis with the Chief Medical Officer or Medical Director. It is the decision of the Chief Medical Officer or Medical Director as to the severity of the incident and whether further action is warranted.

System issues identified by the Health Services staff, the Chief Medical Officer and/or Medical Director are addressed with the individual facilities. The Provider Contracting Department will consider this information during the contracting process.

2. Inpatient Review Program

The inpatient review program is a review process in which admissions and hospital stays are reviewed to assure that inpatient care is medically appropriate; to identify quality of care concerns and opportunities for improvement; to detect and better manage over and underutilization. Nurse reviewers/behavioral health care advocates also review certain care aspects as they relate to Population Health programs and practice guidelines. Discharge planning and care management identification also occurs at this time.

If an admission or continued stay is determined to be medically unnecessary, coverage for those services will not be eligible for authorization and payment. Non-reimbursable charges are not billable to the patient.

3. Notice of Termination of Hospital Benefits

Non-coverage of benefits for admission or continued stay in an Acute Inpatient Hospital, Acute Inpatient Rehabilitation, or Skilled Nursing Facility level of care may occur in a variety of situations. These may include but are not limited to:

- An admission or continued stay which was not prior authorized at an out-of-network facility that has been determined to be not medically necessary.
- An admission for a procedure/service which requires a medical necessity prior authorization which was not prior authorized prior to admission.
- An admission for a procedure/service which requires benefit determination and is determined to be a non-covered benefit.
- An admission for a patient determined by a Medical Director to be custodial and a non-covered benefit.
- An admission for a patient who has utilized all of the existing inpatient or skilled care benefits according to his/her benefit plan (exhaustion of benefits).

If any of the situations listed above occur, the following procedures should take place:

- Notify UHCCP Utilization Management immediately

UHCCP and hospital representatives will deliver a Notice of Termination of Benefits to the member.

4. Admission to an Observation Bed

Observation services are a means to evaluate and determine a patient’s need for hospital admission. Observation may be appropriate when determining response to treatment, or monitoring/diagnosing a MH/SA (mental health/substance abuse) or medical condition. Twenty-three hour observation bed placement is generally used when less than 24 hours is
Observation services may be reviewed for the appropriate use of hospital services and length of stay.

5. Admission to Rehabilitation Units

All rehabilitation confinements require prior authorization for admission and are reviewed concurrently for continued services at this level of care. This benefit is only available for members under 21.

6. Admission to Skilled Nursing Units

**Inpatient hospitalization is not required for a member to be admitted to a Skilled Level of Care.

An individual that may require inpatient skilled nursing care is defined as having had an acute illness, injury, surgery, or exacerbation of a disease process. Skilled nursing care is rendered immediately after, or instead of, acute hospitalization to treat one or more specific, active, medical conditions or to administer treatments that must be performed by licensed professional health personnel. In addition, services must be ordered by a physician and be reasonable and necessary for the treatment of the member’s illness or injury, i.e., be consistent with the nature and severity of the individual’s illness or injury, his particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity. The member must be clinically stable with clinical and lab findings improving/unchanged for the last 24 hours; and diagnosis and initial treatment plan established prior to admission to the skilled nursing facility.

The nature and complexity of a service and the skills required for safe and effective delivery of that service is considered in determining whether a service is skilled. Skilled care requires frequent member assessment and review of the clinical course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care is goal-oriented to progress the patient toward functional independence, and requires the continuing attention of trained medical personnel.

• Prior authorization must occur on all admissions to the skilled facility (or skilled level of care within an acute facility). Initial certification for admissions will be authorized based upon level of care required based upon anticipated treatment plan. The facility must submit documented plan of care including treatment goals, summary of services provided, expected LOS (length of stay), and initial discharge plan.

• Concurrent review is conducted at least weekly, or more often if indicated. The provider (skilled facility) is responsible for providing appropriate/adequate documentation including changes in the level of care. Approval for additional days of authorized coverage must be obtained prior to the expiration of the authorization.

• Determinations regarding levels of care must consider not only level of service but also medical stability of the patient. Disagreements regarding the level of care required are discussed by UHCCP Chief Medical Officer or Medical Director in consultation with the attending physician (managing the patient in the skilled facility, not the transferring attending physician). The appeal procedure can be initiated as desired by the patient and/or authorized representative when coverage is not authorized by UHCCP.
E. Behavioral Health Utilization Management Specifics

1. Behavioral Health Level of Care Guidelines

Mental Health, Substance Abuse and Co-Occurring Disorders

United Healthcare Community Plan currently utilizes the following Level of Care Guidelines (LOCGs) to conduct medical necessity reviews of requests for services as they apply to available Behavioral Health benefits.

The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions - 3rd Edition, 2013 criteria are currently utilized for all Substance Abuse services. ASAM criteria are proprietary and cannot be given to providers or members unless a denial of service(s) is rendered, at which time a copy of the criteria in question can be obtained upon request. Providers wishing to access these criteria independently may purchase them using the following link: http://www.asam.org/publications/the-asam-criteria (The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions - 3rd Edition, 2013

Guidelines currently used for all other levels of care listed below can be found at http://www.uhccommunityplan.com/health-professionals/TN/provider-information

Levels of Care and Services not utilizing ASAM

Adult Residential Treatment (Adult RTC)
Acute Inpatient Hospitalization
Applied Behavioral Analysis
Assertive Community Treatment
Child and Adolescent Residential Treatment (C&A RTC)
Comprehensive Child and Family Treatment (CCFT)
Continued Service
Continuous Treatment (CTT)
Crisis Stabilization Unit (CSU)
Electroconvulsive Therapy (ECT)
Intensive Outpatient
Level I and II Case Management Services
Nursing Home Plus
Outpatient
Partial Hospital
Psychological and Neuropsychological Testing Guidelines
Psychosocial Rehabilitation: Community Support Services
Supported Housing and Enhanced Supported Housing (Combined)

2. Authorization of Benefits for Behavioral Inpatient Services

Inpatient admissions will be directed only to participating hospitals and attending psychiatrists unless there is no available participating provider (e.g. the member has an emergent need for hospitalization while out of state). All inpatient and sub acute level of care admissions, except involuntary psychiatric hospitalization, must be prior authorized by a behavioral health care advocate. Involuntary admissions require a next business day UHCCP notification while all voluntary hospitalizations require the traditional prior authorization. When requesting authorization for an acute level of care, you should be prepared to discuss the clinical presentation of the member including the severity of his/her symptoms. When making a recommendation about the level of care, consider the member’s level of functional impairment and risk factors. A complete copy of the Behavioral Health Level of Care guidelines is available at the UHCCP provider website
at: http://www.uhccommunityplan.com/health-professionals/TN/provider-information. When requested, a paper copy of the level of care guideline will be supplied.

Services provided to members in an inpatient psychiatric or substance abuse unit are reviewed initially and then concurrently by licensed clinicians based on medical necessity. These reviews provide information regarding the member’s clinical status and medical necessity needs for continued inpatient care. Inpatient peer reviews will be conducted directly with the attending psychiatrist whenever possible. UHCCP reserves the right to require a direct conversation with the attending psychiatrist before authorizing coverage for any inpatient stay. In the event benefits are not authorized, UHCCP will recommend alternative less restrictive services or levels of care in accordance with Grier Consent Decree requirements.

Adverse benefit determinations (non-authorizations) may occur for two reasons:

(1) the requested services are not covered under the benefit plan;

(2) there has been a determination that the inpatient admission does not meet medical necessity criteria for the patient’s level of acuity.

Again, when authorization for coverage is not granted, the behavioral health care advocate will work with the clinician or facility to develop an alternative treatment intervention for the member. Whenever an authorization of inpatient services is not granted, UHCCP will notify the member or, in the case of minors or members under custodial care, UHCCP will notify the appropriate custodian. In addition, notification will be made directly to the hospital regarding the adverse determination for continued coverage. The facility is required to inform the member or appropriate custodian immediately of any adverse benefit determination as well as the status of the appeal process in accordance with TennCare notice requirements.

In the event of an emergency admission, clinicians should notify UHCCP as soon as possible or, at the latest, the next business day. Conditions that warrant an emergency admission are situations in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance abuse. Requests for initiation of inpatient rehabilitative substance abuse treatment are not considered to be emergencies, and will be evaluated during the next business day. If appropriate, UHCCP will retrospectively authorize coverage of admissions for emergency services provided; however, depending on the specific circumstances of each individual case, UHCCP reserves the right to deny coverage for all or part of an admission. All requests for retrospective reviews must be received by UHCCP within 120 calendar days of the date the services were provided to the member, unless state law mandates otherwise. This rule does not apply to reviews based on retro eligibility.

3. Authorization of Benefits for Behavioral Outpatient Services

In most cases routine outpatient services, such as visits for medication management and/or traditional outpatient therapy, do not require authorization. Forms of non-team based case management services may require either a registration or authorization process by UHCCP. All other outpatient services must have prior authorization by a behavioral health care advocate. See the “Services that Require Prior Authorization and Contact Information” section of this manual for a complete listing of services that require prior authorization. When requesting authorization for an outpatient level of care, you should be prepared to discuss the clinical presentation of the plan participant including the severity of the member’s symptoms.
When making a recommendation about the level of care, consider the member’s level of functional impairment and risk factors. A complete copy of the Behavioral Health Level of Care guidelines is available on the UHCCP provider website at http://www.uhccommunityplan.com/health-professionals/TN/provider-information. You may also request a printed copy of these guidelines from your Behavioral Health network manager or by calling 800-690-1606.

Services provided to members in an outpatient level of care that requires prior authorization are reviewed initially and then concurrently by licensed clinicians based on clinical appropriateness. These reviews provide information regarding the members’ clinical status and medical necessity needs for continued outpatient care. UHCCP reserves the right to require a direct conversation with the treating physician before authorizing coverage for any continued stay. In the event benefits are not authorized, UHCCP will support clinicians or hospital staff to maximize benefits that are available.

Adverse benefit determinations may occur for two reasons:

(1) The requested services are not covered under the benefit plan;

(2) There has been a determination that the outpatient service does not meet clinical guidelines for the member’s level of acuity or does not adhere to standards of best practice.

Again, when authorization for coverage is not granted, the behavioral health care advocate will work with the clinician or facility to develop an alternative treatment intervention for the member. Whenever an authorization for coverage of outpatient services is not granted, UHCCP will notify the member or, in the case of minors or members under custodial care, UHCCP will notify the appropriate custodian. In addition, notification will be made directly to the outpatient provider regarding the adverse determination for continued coverage. The facility is expected to inform the member or appropriate custodian immediately of any adverse benefit determination as well as the status of the appeal process in accordance with TennCare notice requirements.

4. Retrospective Review Process

A retrospective review occurs only on those rare occasions when an initial request for authorization is made after services have already been delivered. For all retrospective reviews, UHCCP will issue a determination within 30 calendar days of receipt of the request. Any retrospective review request received outside 120 calendar days from the initial date of service will be denied based on timely filing rules.

5. Psychological and Neuropsychological Testing

All psychological testing must be prior authorized for both outpatient and inpatient services.

Psychological testing is considered after a standard evaluation including clinical interview, observation and collection of collateral information (as indicated), has been completed and one of the following circumstances exists:

• There are significant diagnostic questions remaining that can only be clarified through testing.

• There are questions about appropriate treatment course for the patient or the patient has not responded to standard treatment with no clear explanation and testing would have a timely effect on the treatment plan.

• There is reason to suspect, based on the initial assessment, the presence of cognitive or intellectual deficits that may affect functioning or interfere with the patient’s ability to participate in or benefit from treatment and testing will verify the presence or absence of such deficits.
• There is reason to suspect the presence of neuropsychological dysfunction that may adversely affect functioning or interfere with the patient’s ability to participate in or benefit from treatment and testing can clarify the presence or absence of such dysfunction.

Generally, psychological testing for school evaluations, learning disabilities, developmental delays, admission to organizations and for judicial reasons are not covered behavioral health services. Testing is not generally authorized when:

• It is done routinely as part of an assessment.
• It is excluded as a covered benefit by the plan.
• It is to determine the extent of neurological damage.
• It is purely to meet a court order, educational requirement, or other administrative orders or requirements.

Neuropsychological testing no longer requires prior authorization. Neuropsychological testing can be covered under the medical or behavioral health benefit depending on the situation. When neuropsychological evaluations are requested by medical providers and are related to diagnoses of pain, primary sleep disorders, brain injury and other neurological disorders, etc., the evaluation may be covered under the UHCCP medical benefit.

Generally, authorization of benefits is only for the time involved in direct contact with the patient or family and not for scoring, interpreting or report writing. If you have questions regarding coverage for psychological testing you will find more extended testing guidelines on the UHCCP website at http://www.uhcommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-PsychologicalNeuropsychologicalTesting.pdf or you can contact UHCCP at 800-690-1606.

6. Managing Expectations Through Education

We encourage you to educate members about what to expect when they present for treatment. Members will benefit from clear explanations about their diagnosis, prognosis, treatment options, the potential benefits and side effects of medication (if medication is indicated), and the projected length and course of the treatment episode. You can assist members in managing their expectations about treatment by explaining that treatment will be focused on their current presenting problems/symptoms and that not all of the therapeutic work to be done will occur in the office. Discussing therapeutic homework, community support and ancillary interventions early in the therapeutic process helps establish realistic expectations about treatment and may also set the stage for greater compliance with recommended treatment over time.

We encourage you to discuss with all UHCCP members, their treatment options, and the associated risks and benefits, regardless of whether the treatment is covered under their benefit plan. Nothing in this Manual is intended to interfere with your relationship with members as patients.

7. Discharge and Treatment Planning

Effective discharge planning addresses how a member’s needs will be met as he or she moves from one level of care to another or to a different treating clinician. Treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care. Effective planning is a key indicator of the ongoing health and well-being of a member following acute care. Behavioral health care managers will work with you to begin the discharge or treatment planning process for UHCCP participants at the time that services are initiated.

As appropriate, the discharge or treatment planning process will involve a behavioral health care manager, the current clinician, the member, the member’s family, the clinician at the next level of care, and/or relevant community resources. Discharge planning involves assessment of the member’s needs and the clinician’s ability to address those needs, as well as the best and most effective means by which these needs can be met. It is essential to the maintenance of therapeutic gains that members be
educated regarding the importance of enlisting community support services, communicating treatment recommendations to all involved treating professionals, and adherence to follow-up care throughout the discharge and treatment planning process. Members have the right to decline the release of information but should be informed about the risks and benefits of this decision.

To ensure continuity of care for members discharging from acute and residential levels care, UHCCP requires that a discharge summary is provided to UHCCP within twenty-four (24) hours of member discharge from the facility. Discharge summary requirements at a minimum include:

- Member Name
- Discharge location and phone number, if available
- At least one behavioral health follow-up appointment scheduled within seven (7) calendar days of discharge, other than mental health case management (unless member refuses aftercare).

Full Discharge Plan Development Requirements are located in the Forms Appendix and on the provider website at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-BH-DischargePlanRequirements.pdf

Instructions for Completing the Inpatient Discharge Summary are located in the Forms Appendix and on the provider website at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-BH-DischargeInstructionsForm.pdf

The Discharge Summary Form is located in the Forms Appendix and on the provider website at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TNBH-DischargeSummary.pdf

8. Continuation of Services after Provider Termination

Network clinicians who wish to withdraw from the Behavioral Health network are required to notify UHCCP, in writing, 120 days prior to the date of withdrawal. Upon withdrawal, these providers are obligated to continue to provide treatment for all UHCCP members under their care at the date of the contract termination for a maximum of 90 calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less. During this 90-day post termination period, all services that were previously prior authorized will be reimbursed at the contracted rate. In some cases, you and the behavioral health care manager may determine it is in the best of interest of the member to extend care beyond this timeframe and UHCCP will arrange to continue authorization for such care at the contracted rate of reimbursement. UHCCP must give notice to effected members of a clinician's anticipated change in network status prior to the contract termination in order to comply with TennCare requirements.

9. Communication with the PCP and other Health Care Professionals

To appropriately coordinate and manage care between behavioral health care clinicians and medical professionals, UHCCP asks that clinicians attempt to obtain the member's consent to exchange treatment information with medical care professionals (i.e. primary physicians, medical specialists) and/or other behavioral health care clinicians (psychiatrists, therapists). Coordination and communication should take place at: the time of intake, during treatment, the time of discharge or termination of care, and between levels of care.

The coordination of care between behavioral health care clinicians and medical care professionals improves the quality of care to our plan participants in several ways:
• Communication can confirm for a primary physician that his or her patient followed through on a referral to a behavioral health professional.

• Coordination minimizes potential adverse medication interactions for member’s prescribed psychotropic medication.

• Coordination allows for better management of treatment and follow up for members with coexisting behavioral and medical disorders.

• Continuity of care across all levels of care and between behavioral and medical treatment modalities is enhanced.

• For members with substance abuse disorders, coordination can reduce the risk of relapse.

The following guidelines are intended to facilitate effective communication:

• During the diagnostic assessment session, request the patient's written consent to exchange information with all appropriate treatment professionals.

• Following the initial assessment, provide other treating professionals with the following information within two weeks:
  
  • Summary of patient’s evaluation
  
  • Diagnosis
  
  • Treatment plan summary (including any medications prescribed)
  
  • Primary clinician treating the patient
  
  • Update other behavioral health clinicians and/or primary or referring physicians when the patient’s condition or medications change.

• At the completion of the treatment, send a copy of the termination summary to the other treating professionals.

Some members may refuse to allow for release of this information and this decision must be noted in the clinical record. Both accreditation bodies and UHCCP expect all clinicians to make a “good faith” effort at communicating with other behavioral health clinicians and any medical care professionals who are treating the plan participant.

F. Peer-to-Peer Process

Peer review is an integral part of the Medical/Utilization Management Program. The Medical Director reviews issues relating to quality of care and patient safety. These issues are reviewed on a case-by-case basis and takes into consideration individual patient circumstances. The Peer Review process recognizes best practice, community standards of care, and the local health care systems.

The Peer-to-Peer process provides the licensed provider the opportunity to discuss an adverse determination with a professional with similar types and degrees of expertise, if no such discussion took place during the review. This
conversation must occur with the Medical Director or physician designee who made the adverse determination, unless they are unavailable. If unavailable, the covering Medical Director will facilitate the Peer-to-Peer.

The Peer-to-Peer conversation should be conducted telephonically within one (1) business day of the request and:

• Should include the review of all previously available information and all newly provided information, and

• Be conducted by the same Medical Director who made the initial non-coverage determination (if applicable), or by a designated Medical Director when the original Medical Director is not available within one (1) business day.

• If an adverse determination has been made for an inpatient admission or stay, the licensed provider should request a Peer-to-Peer within 24 hours or one (1) business day of notification of the decision, but no later than 24 hours or two (2) business days after discharge. The conversation will then be scheduled within the next business day so that the completion of the reconsideration occurs within two (2) business days. If the Peer-to-Peer cannot be completed within two (2) business days (or after the Medical Director has made 2 attempts to contact the treating physician) the provider will be made aware of the UHCCP’s formal appeals process to be followed.

• If an adverse determination has been made for a physical health service requiring prior authorization, the provider must request a Peer-to-Peer conversation within fifteen (15) days of notification of the decision. If the request is received after 15 days, the provider will be notified to follow the Provider Dispute process.

• Timeframes for completion of the Peer-to-Peer process vary for Behavioral Health according to the Level of Care as follows:
  – Inpatient Peer-to-Peer conversations should be completed within the hour, except for after hours and weekends. In those cases, the Peer-to-Peer conversation will be completed the next business day.
  – Outpatient Peer-to-Peer conversations should be completed within fourteen (14) calendar days of the request.

G. Medical Necessity Policy

Medically necessary is defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term "medically necessary", as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare members. Implementation of the term "medically necessary" is provided for in regulations at 1200-13-16, consistent with the statutory provisions, which control in case of ambiguity. No member shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services, as defined either in the statute or in regulations at 1200-13-16. The TennCare Rules can be found at http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm.

Medical Necessity Criteria

1. To be medically necessary, a medical item or service must satisfy each of the following criteria:

   a. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member;

   b. It must be required in order to diagnose or treat an member’s medical condition;
c. It must be safe and effective;

d. It must not be experimental or investigational; and

e. It must be the least costly alternative course of diagnosis or treatment that is adequate for the member’s medical condition.

2. The convenience of a member, the member’s family, the member’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 a member’s medical condition must be in accordance with the following:

a. Provided that all the other medical necessity criteria are satisfied, services required to diagnose a member’s medical condition may include screening services, as appropriate.

b. Screening services are “appropriate” if they meet one of the following three categories:

1. Services required to achieve compliance with Federal statutory or regulatory mandates under the EPSDT program;

2. Newborn testing for metabolic/genetic defects as set forth in Tennessee Code Annotated, Section 68-5-401; or

3. 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 Bureau of TennCare.

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

1. The Bureau of TennCare, an MCO, or a state agency performing the functions of a managed care contractor determines that the screening services are cost effective;

2. The screening must have a significant probability of detecting the disease;

3. The disease for which the screening is conducted must have a significant detrimental effect on the health status of the affected person;

4. Tests must be available at a reasonable cost;

5. Evidence-based methods of treatment must be available for treating the disease at the disease stage which the screening is designed to detect; and

6. Treatment in the asymptomatic phase must yield a therapeutic result.
4. Services required to treat a member’s medical condition are considered medically necessary provided that all other elements of medical necessity are satisfied. Treatment of a member’s medical condition may only include:

a. Medical care that is essential in order 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.

b. Medical care that is essential in order to treat the significant side effects of another medically necessary treatment (e.g., nausea medications for side effects of chemotherapy).

c. 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.

d. Home health services.

1. Home health aide services are necessary to treat a member’s medical condition only if such services;

   i. Are of a type that the member cannot perform for himself or herself;

   ii. Are of a type for which there is no caregiver able to provide the services; and

   iii. Consist of hands-on care of the member.

2. All other home health services are necessary to treat an member’s medical condition only if they are ordered by the treating physician, are pursuant to a plan of care, and meet the requirements described at subparagraph (a), (b), or (c) immediately above or (f) immediately below. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an member’s medical condition and will not be provided. Because 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 present at all times in the home during provision of home health or private duty nursing services unless all of the following criteria are met:

   i. The child is non-ambulatory; and

   ii. The child has no or extremely limited ability to interact with caregivers; and

   iii. The child shall not reasonably be expected to have needs that fall outside the scope of medically necessary TennCare covered benefits (e.g., the child has no need for general supervision or meal preparation) during the time the home health provider or private duty nurse is in the home without the presence of another responsible adult; and

   iv. No other children shall be present in the home during the time the home health provider or private duty nurse is present in the home without the presence of another responsible adult.
3. Private Duty Nursing services are separate services from home health services. When private duty nurses are authorized by UHCCP to provide home health aide services, these services must meet the requirements described in Section 1 above.

4. Home health services may not be denied on any of the following grounds:
   
   i. Because such services are medically necessary on a long-term basis or are required for the treatment of a chronic condition;
   
   ii. Because such services are deemed to be custodial care;
   
   iii. Because the member is not homebound;
   
   iv. Because private insurance utilization guidelines, including but not limited to those developed in-house by TennCare managed care contractors, do not authorize such health care as referenced above;
   
   v. Because the member does not meet coverage criteria for Medicare or some other health insurance program, other than TennCare;
   
   vi. Because the home health care that is needed does not require or involve a skilled nursing service;
   
   vii. Because the care that is required involves assistance with activities of daily living;
   
   viii. Because the home health service that is needed involves home health aide services; or,
   
   ix. Because the member meets the criteria for receiving Medicaid nursing facility services.

e. Personal Care Services

1. Personal care services are necessary to treat an member’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 as a result 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:
   
   i. Be of a type that the member cannot perform for himself or herself;
   
   ii. Be of a type for which there is no caregiver able to provide the services; and
   
   iii. Consist of hands-on care of the member.

2. Services that do not meet these requirements, such as general child care services, cleaning services or preparation of meals, are not required to treat an member’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 present at all times during provision of personal care services.
f. The following preventive services:

1. Prenatal, maternity, and postpartum care delivered in accordance with standards endorsed by the American College of Obstetrics and Gynecology;

2. Family planning services;

3. Age-appropriate childhood immunizations delivered according to guidelines developed by the Advisory Committee on Immunization Practices;

4. Health education services for TennCare-eligible children under age 21 in accordance with 42 U.S.C. Section 1396d;

5. Other preventive services that are required to achieve compliance with Federal statutory or regulatory mandates under the EPSDT program; or

6. Other preventive services that have been endorsed by the Bureau 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 member or group of members.

5. Safe and effective services must meet the following criteria:

a. To qualify as being safe and effective, the type, scope, frequency, intensity, and duration of a medical item or service must be consistent with the symptoms or confirmed diagnosis and treatment of the particular medical condition. The type, scope, frequency, intensity, and duration of a medical item or service must not be in excess of the member’s needs.

b. The reasonably anticipated medical benefits of the item or service must outweigh the reasonably anticipated medical risks based on:

1. The member’s condition; and

2. The weight of medical evidence as ranked in the hierarchy of evidence in Rule 1200-13-16-.01(21) and as applied in Rule 1200-13-16-.06(6) and (7).

6. Not experimental or investigational services must meet the following criteria:

a. A medical item or service is not experimental or investigational if the weight of medical evidence supports the safety and efficacy of the medical item or service in question as ranked in the hierarchy of evidence in Rule 1200-13-16-.01(21) and as applied in Rule 1200-13-16-.06(6) and (7). This standard is not satisfied by a provider’s subjective clinical judgment on the safety and effectiveness of a medical item or service or by a reasonable medical or clinical hypothesis based on an extrapolation from use in diagnosing or treating another condition. However, extrapolation from one population group to another (e.g. from adults to children) may be appropriate. For example, extrapolation may be appropriate when the item or service has been proven effective, but not yet tested in the population group in question.
b. Subject to the provisions set forth in subparagraph (c) immediately below, use of a drug or biological product that has not been approved for marketing under a new drug application or abbreviated new drug application by the United States Food and Drug Administration (FDA) is deemed experimental.

c. Use of a drug or biological product that has been approved for marketing by the FDA but is proposed to be used for other than the FDA-approved purpose (i.e., off-label use) is experimental and not medically necessary unless the off-label use is shown to be widespread and all other medical necessity criteria as set forth in Rule 1200-13-16-.05(1)(a), (b), (c) and (e) are satisfied.

d. Items or services provided or performed for research purposes are experimental and not medically necessary. Evidence of such research purposes may include written protocols in which evaluation of the safety and efficacy of the service is a stated objective or when the ability to perform the service is contingent upon approval from an Institutional Review Board, or a similar body.

e. Unless a proposed diagnosis or treatment independently satisfies the criteria for “not experimental or investigational”, and satisfies all other medical necessity criteria, the fact that an experimental/investigational treatment is the only available treatment for a particular medical condition or that the patient has tried other more conventional therapies without success does not qualify the service for coverage.

7. A service is considered medically necessary if it is the least costly alternative course of diagnosis or treatment that is adequate for the medical condition of the member.

a. Where there are less costly alternative courses of diagnosis or treatment that are adequate for the medical condition of the member, more costly alternative courses of diagnosis or treatment are not medically necessary, even if the less costly alternative is a non-covered service under TennCare.

b. Where there are less costly alternative settings in which a course of diagnosis or treatment can be provided that is adequate for the medical condition of the member, the provision of services in a setting more costly to TennCare is not medically necessary.

c. If a medical item or service can be safely provided to a person in an outpatient setting for the same or lesser cost than providing the same item or service in an inpatient setting, the provision of such medical item or service in an inpatient setting is not medically necessary and TennCare shall not provide payment for that inpatient service.

d. An alternative course of diagnosis or treatment may include observation, lifestyle, or behavioral changes or, where appropriate, no treatment at all when such alternative is adequate for the medical condition of the member.

e. The following is a non-exhaustive illustrative set of circumstances that could fit within the provisions of Rule 1200-13-16-.05(7)(d). These examples may or may not be appropriate, depending on an individualized medical assessment of a patient’s unique circumstances:

1. Rest, fluids and over-the-counter medication for symptomatic relief might be recommended for a viral respiratory infection, as opposed to a prescription for an antibiotic;
2. Rest, ice packs and/or heat for acute, uncomplicated, mechanical low back pain along with over-the-counter pain medicine, as opposed to x-rays and a prescription for analgesics;

3. Clear liquids and advance diet as tolerated for uncomplicated, acute gastroenteritis, as opposed to prescription for anti-diarrheal drug.

8. The Bureau of TennCare may make limited special exceptions to the medical necessity requirements described at Rule 1200-13-16-.05(1) for particular items or services, such as long term services and supports, or such as may be required for compliance with Federal law.

9. Transportation services that meet the requirements described at Rule 1200-13-13-.04 and 1200-13-14-.04 shall be deemed to be medically necessary if provided in connection with medically necessary items or services.

**H. Criteria used for Medical Management Decisions**

Reviewers for UHCCP are allowed to make decisions to approve care based on specific criteria. These criteria are of two types:

1. **Externally Developed Criteria**

Nationally recognized review criterion is used to guide the nurse reviewer/behavioral health advocate in approving inpatient care. Review criteria will be reviewed and approved annually by the Chief Medical Officer. Updates occur annually or as necessary or when provided. Other criteria may be substituted when there is published peer reviewed literature support for admission or continued stay criteria. All criteria are subject to the review and approval process.

2. **Internally Developed Approval Criteria**

UHCCP may develop standards for medical appropriateness (approval criteria) i.e. Level of Care Guidelines. These guidelines are reviewed and revised annually utilizing a literature review search of new articles pertaining to levels of care as well as input solicited from providers. Medical necessity criteria are available to network physicians upon request by contacting Customer Service at 800-690-1606.

All Utilization Management decisions are objective and use evidence-based criteria taking into consideration individual circumstances and the local delivery system. They are based on appropriateness of care and service and the existence of coverage. Utilization Management decision makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization.

**I. Emergency, Post Stabilization and Urgent Care Services/After Hours Calls**

Members are encouraged to receive Emergency Services from their PCP or a Participating Hospital or Facility.

Behavioral Health Crisis Services are available 24/7. For adults, 18 years and older, crisis services can be accessed by calling 855-274-7471. For children under 18 years of age, please refer to the following information:
Region 1: Frontier Health 877-928-9062
Region 2: Youth Villages 1-866-791-9223
Region 3: Helen Ross McNabb 865-539-2409
Region 4: Youth Villages 1-866-791-9224
Region 5: Youth Villages
  • Upper Cumberland 1-866-791-9223
  • Southeast 1-866-791-9225
Region 6: Mental Health Cooperative 615-726-0125
Region 7: Youth Villages 1-866-791-9222
Region 8: Youth Villages 1-866-791-9227
Region 9: Youth Villages 1-866-791-9227
Region 10: Youth Villages 1-866-791-9227
Region 11: Youth Villages 1-866-791-9227
Region 12: Youth Villages 1-866-791-9226
UHCCP covers Emergency, Post-stabilization, and Urgently Needed Services without prior authorization whether the member is in or out of the service area or if the care is provided by participating or non-participating providers. All non-emergency services must be provided or coordinated by participating providers. Members who present at an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening.

A member is encouraged to contact their PCP as soon as possible, preferably within twenty-four (24) hours after an Emergent/Urgent Service Procedure. The member’s PCP is expected to work with the member to coordinate any follow-up care. As a participant in UHCCP’s network, the PCP is responsible for the emergency medical direction of members 24/7.

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 pregnant women, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

1. **Post-Stabilization Care Services**

Post-stabilization services are covered services related to an emergency medical condition that aid in the stabilization of a member’s condition. These services are rendered in order to improve or resolve the member’s condition under the circumstances described in 42 CFR 438.114(e). Retrospective review of post stabilization care services are claim coverage decisions that are based upon the severity of symptoms at the time of presentation.

Post-stabilization services, including all medical and behavioral health services that are necessary to assure there is no likely material deterioration of the member’s condition after discharge or during transport to another facility, are also covered based upon the prudent layperson standard. If either the member’s PCP or UHCCP directs the member to the Emergency Room, emergency screening services and other medically necessary emergency services will be reimbursed, whether or not the member’s condition meets the prudent layperson definition of an emergency medical condition.

2. **Urgent Care**

Non-network providers will be reimbursed for urgently needed services to treat an unforeseen illness, injury or condition when such services are Medically Necessary and immediately required as a result of unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through his/her Network Provider.
Members are encouraged to contact their PCP and/or Specialist to seek guidance in urgent or emergency medical conditions. Please remember that all subsequent follow-up care must be provided or coordinated by the member’s Participating Physician.

3. Emergency Services in the Emergency Room

UHCCP covers all emergent services necessary to stabilize members, without prior authorization of the services, where a prudent layperson could reasonably expect that an emergency medical condition existed. Screening services to determine whether an emergency medical condition exists are covered services.

If there is disagreement regarding the member’s stabilized condition at the expected time of discharge or transfer, the decision of the attending physician will prevail. UHCCP may arrange for a participating physician with appropriate emergency room privileges to assume the attending provider’s responsibilities to stabilize, treat and transfer the member. This situation can only occur when the arrangement does not delay the provision of emergency services.

4. Emergency Inpatient Admission

Should the attending physician proceed and admit the member, UHCCP must be notified no later than the end of the next working day. Once the member’s condition is stabilized, UHCCP requires notification for hospital admission and follow up care. Should the hospital fail to notify UHCCP within ten (10) calendar days following a member’s presentation for emergency inpatient admissions, charges deemed not medically necessary by UHCCP’s Medical Director, could become the financial responsibility of the hospital. The member will be held harmless in this situation.

5. Billing for Hospital Observation Beds

There are specific requirements for billing for observation services. Please refer to Chapter VI, Section E for further guidance.

J. Continuity and Coordination of Care

Continuity and Coordination of Care is monitored in the following areas:

- Mental Health and Substance abuse
- Specialty Care
- Hospital
- Home Health and other ancillary providers
- Transplant Services
- Health Departments that provide care to members
- ER use review
- Medical Record Review
- Referral & Preauthorization Process
- Population Health process
- Access & Availability process
- Cultural/Linguistics process

Continuity and coordination of care between members and providers delivering specialty services such as home health, health departments, Centers of Excellence for transplants, tertiary care hospitals and sub acute facilities are monitored by
the case managers and regional UM/CM staff. Continuity of care is also monitored by ambulatory medical record review, inpatient concurrent review, and pharmacy claims data analysis.

The Utilization Management/Care Management staff work closely with providers to ensure there is the integration of physical, mental health, and substance abuse care. Should providers encounter difficulties in securing medically necessary, covered services for UHCCP members, the UM/CM and Customer Service staff are able to assist. These individuals can be reached by contacting Customer Service at 800-690-1606.

Providers of physical health care are encouraged to assess patients for mental health and substance abuse problems and refer as appropriate. Assessment screening tools are available at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Provider-Information/TN-BehavioralHealthToolkit.pdf or by contacting Customer Service at 800-690-1606. A copy of the form can be found in the Forms Appendix.

Providers of mental health services should evaluate members in their care for physical health and substance abuse problems. Substance abuse providers should evaluate for physical health and mental health problems.

All providers should refer members for services as appropriate and acceptable to the member. The PCP has the overall responsibility for the continuity of patient care and should receive treatment information and regular care updates from specialty providers, including mental health and substance abuse providers.

Specialty providers, including mental health and substance abuse providers have the responsibility to provide regular care updates to the members PCP within the guidelines of member confidentiality.

The following are tools for monitoring continuity and coordination of care:

- Member complaint information
- Customer service logs
- Network physician input
- Practitioner satisfaction surveys
- Concurrent review
- Care management

When opportunities for improvement occur, UHCCP staff will intervene to improve any necessary processes and outcomes.
X. Clinical Practice Guidelines

A. Practice Guidelines for Physical Health
Nationally recognized guidelines are reviewed by UHCCP practicing physicians prior to adoption. All guidelines are reviewed at a minimum of every two years and as the guidelines change. Guidelines are distributed to the network providers via provider newsletters and on the provider website. Periodic reminders about the guidelines or some component of the guidelines are inserted in provider newsletters. In addition, UHCCP has placed Physical Health Practice Guidelines on the provider website at: http://www.uhccommunityplan.com/health-professionals/TN/clinical-practice-guidelines. You may also obtain a copy of these guidelines by contacting Customer Service at 800-690-1606.

Member education is provided via individual program materials, the member newsletter, and on the UHCCP member website at uhccommunityplan.com. Performance of clinical programs is measured and analyzed annually to identify opportunities for improvement.

B. Practice Guidelines for Behavioral Health
UHCCP has elected to adopt Clinical Practice Guidelines (CPGs) from established professional organizations, such as the APA, the AACAP, and the AAP. The most prevalent diagnostic categories have established CPGs and these CPGs are updated or revised periodically. Available CPGs endorsed by UHCCP can be found on the provider website at http://www.uhccommunityplan.com/health-professionals/TN/clinical-practice-guidelines.

Copies of the CPGs can also be obtained by contacting Customer Service at 800-690-1606.
XI. Population Health

A. Program Overview

At the request of TennCare, effective January 1, 2013, UnitedHealthcare Community Plan has transitioned our Disease Management and Case Management Programs into a comprehensive and integrated Population Health Management Program.

Population Health is intended to provide coordinated versus episodic care to members over time. To be effective, it requires greater collaboration between hospitals, physicians, other providers and health plans to improve the continuity of health and care support for all members. This approach, once effectively implemented, can result in improved quality and health outcomes within sustainable costs. This can be achieved by keeping healthy people engaged to maintain their good health; to share and use predictive analytics to identify and proactively manage at-risk populations to reduce costly and acute events, and; to integrate care coordination and provider support that results in improved patient compliance and self-management to minimize the severity and frequency of recurring and costly episodes of care.

To achieve this, UnitedHealthcare Community Plan has developed new tools and integrated solutions to partner with hospitals and physicians including information sharing, care coordination, member engagement, and financial incentives. We continue to contact providers who have patients participating in the higher levels of Health Risk Management, Maternity Management, Chronic Care Management and Complex Case Management to discuss ways we can jointly support these patients.

UnitedHealthcare Community Plan supports every member with cost effective and appropriate interventions based on their stratification into one of three risk levels defined by TennCare. These risk levels include:

- Level 2 includes three (3) programs:
  - Complex Case Management
    Includes members who are not pregnant and have high risk, unique or complex needs. It may also include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. The goal of this program is to move members to optimal levels of health and well-being by providing timely coordination of quality services and self-management support. This is an opt in program (member must agree to participate).
  - Chronic Care Management
    Includes members who have high risk, unique or complex needs and may include members with co-occurring mental illness and substance abuse and/or co-morbid physical and behavioral health conditions. The goal of this program 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. This is an opt in program (member must agree to participate).
  - High Risk Maternity (Healthy First Steps)
    Includes pregnant members who are identified as with physical or behavioral health risk indicators including drug, alcohol and tobacco use. The goal of this program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. This is an opt in program (member must agree to participate).
• Level 1 includes three (3) programs:

  - **Health Risk Management**
    Includes members who have chronic conditions, including all the chronic conditions that were managed in our Population Health program, plus members who use tobacco or need help with weight management. The goal of this program is to empower members to be proactive in their health and to support the provider-patient relationship. This program is operated as an opt out program (members are included unless they specifically ask to be excluded).

  - **Low Risk Maternity (Healthy First Steps)**
    Includes all pregnant women who don’t meet criteria for the high risk maternity program. The goal of this program is to engage pregnant women into timely prenatal care and aim for delivery of a healthy, term infant without complications. This program is operated as an opt out program (members are included unless they specifically ask to be excluded).

  - **Care Coordination**
    An intervention in the Population Health Program that is used to ensure that members get the services they need to prevent or reduce an adverse health outcome. Members may or may not have a chronic condition but they will generally have acute health needs or risks that warrant immediate attention. Care Coordination services include making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to Member’s immediate needs, PCP reconnection or offering other resources/ materials related to wellness, lifestyle and prevention.

• Level 0, Wellness

  Includes members who are not pregnant, do not use tobacco, are not obese and have no identified chronic conditions. The goal of this program is to help keep these members healthy as long as possible.

For more information on these programs or to refer patients into one of these Population Health Management Programs, call Customer Service at (800) 690-1606 or contact your UHC Provider Advocate directly. Patients may also call this number to self refer.
A. Introduction to Healthy First Steps

UHCCP has developed a Maternal/Prenatal program for all of its pregnant members. Healthy First Steps (HFS) is available to all members. Education related to physical and emotional aspects of pregnancy, healthy lifestyles and the recognition and reporting of pregnancy related complications are covered benefits. In addition, women with identified risk(s) are offered case management services provided by OB experienced Registered Nurses and Licensed Social Workers. HFS is a voluntary program and members may opt out at any time.

Members are identified by eligibility, claims, lab and pharmacy data in addition to internal referrals, member self-referral and provider referrals. Providers are encouraged to make HFS referrals by submission of a Maternity CM notification form available online at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-MaternityCMNotificationForm.pdf.

Identified members are contacted by phone for program information, risk assessment and program enrollment which may include Case Management (CM) services. Providers receive notification of HFS CM services with assigned CM contact information. A Plan of Care (POC) is developed for all members enrolled in Case Management. Health care providers are encouraged to be actively involved with the POC throughout the pregnancy and to contact assigned CM for collaboration throughout the pregnancy.

B. OB Care Management and Coordination

Healthy First Steps authorizes all requests for inpatient admissions and outpatient requests requiring an authorization. There is no requirement to obtain a global authorization for provider prenatal services or facility pre authorization of care for delivery. Requests for sterilization must be completed 30 days prior to the procedure. Prior authorization forms are available in English and Spanish and may be accessed online at: http://www.hhs.gov/opa/pdfs/consent-for-sterilization-english-updated.pdf and/or http://www.hhs.gov/opa/pdfs/consent-for-sterilization-spanish-updated.pdf

C. Authorization/Billing of Makena/17-alpha-hydroxyprogesterone (17P)

The coverage criteria and options for administration may be accessed at: http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/17P_Makena_Injection_Policy.pdf.

Prior authorization form may be accessed at: http://www.uhccommunityplan.co/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Makena%20Prior%20Auth%20Form.pdf

D. Presumptive Eligibility

Presumptively eligible pregnant women will present with a letter completed by a local county health department. These letters must be accepted as verification of eligibility. Please retain a copy for your records.
XIII. TennCare Kids (EPSDT)

A. Introduction to TennCare Kids (EPSDT) Early and Periodic Screening, Diagnosis, and Treatment of Children

Screening, diagnostic, and follow-up treatment services are covered when medically necessary in agreement with TennCare and Federal regulations, including TennCare rules and regulations, TennCare policies and procedures, Federal requirements as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for members under 21.

All children and teens under 21 who have TennCare should receive regular checkups. These regular checkups help find health, speech, hearing, vision, dental, mental health, and drug or alcohol problems. TennCare pays for medicine and treatments when medically necessary. Members under the age of 21 may be referred for behavioral health services as a result of the EPSDT screening by a healthcare professional. Behavioral health providers will provide diagnostic and treatment services in accordance with the EPSDT screening or diagnosis findings.

In the event that a member under sixteen (16) years of age is seeking behavioral health TennCare Kids services and the member’s parent(s) or legally appointed representative is unable to accompany the member to the assessment, the provider shall contact the member’s parent(s) or legally appointed representative to discuss the findings and inform the family of any other necessary behavioral health treatment recommended for the member. If the provider is unsuccessful in contacting the parent(s) or legal representative, the provider must inform UHCCP to contact the parent(s) or legal representative.

B. TennCare Kids (EPSDT) Screening Guidelines

1. Periodicity Schedule for Check-ups and Screenings

Any time a TennCare member is in your office, you should ask if they have had their age appropriate TennCare Kids physical for that year. There are many opportunities to provide or schedule services when the member is in your office for other purposes or on the telephone with office staff. If the member has not had their age appropriate physical, an EPSDT examination should be performed, including any necessary immunizations. A WIC (Women, Infants, Children) visit is not considered a TennCare Kids visit. It is also very important that delivery of these services is documented in the patient’s medical record. Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services. No prior authorization is required for TennCare Kids screenings; however, a referral to a specialist is required if necessary for completion of the exam or for treatment of problems discovered during the exam.

TennCare requires that TennCare Kids screenings be performed according to the standards in the periodicity schedule of the Tennessee Chapter of the American Academy of Pediatrics. Interperiodic screenings are available whenever a person like a teacher or parent notices a change that might require a screening.

UHCCP sends each TennCare Kids eligible member reminders to schedule an EPSDT exam. Please help us assist our members in obtaining their TennCare Kids well-visit exams.
UnitedHealthcareOnline.com is your one stop for online provider tools, reports and resources. This website has features to help streamline care for your patients.

Registration is required for your practice and the Tax ID number is required. You will need to create a user name and password for your office. Visit https://www.unitedhealthcareonline.com for complete instructions and to sign up today. For instructions on gaining access to your reports visit: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Help/Reports.pdf

### 2. Medical Record Requirements

Annually, UHCCP and the Bureau of TennCare conduct medical record reviews for compliance with TennCare Kids services. There are specific components of screening examinations that must be documented in the medical record. Details regarding these components are listed in the Medical Record Review section of this Manual.

Participating Provider’s office medical records will be reviewed against the TennCare recommended components of EPSDT exams. UHCCP will utilize the TennCare Audit Form for the office medical record review. Offices are selected for audit based upon the services billed by the provider under TennCare Kids service codes. These codes are listed in the Billing and Reimbursement chapter of this Manual (See Chapter VI).

The Tennessee Chapter of the American Academy of Pediatrics (TNAAP) recommends the use of EPSDT/TennCare Kids encounter forms for all EPSDT encounters. The encounter forms are available on the TNAAP

### TennCare Kids Screening Schedule

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<tr>
<th>Infancy</th>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescence</th>
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<tr>
<td>At birth</td>
<td>15 months old</td>
<td>Five years old</td>
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<td>Three to five days</td>
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website at [http://www.tnaap.org/Files/EPSDT/TNAAP_Original_Forms_12-12-12.pdf](http://www.tnaap.org/Files/EPSDT/TNAAP_Original_Forms_12-12-12.pdf). They can also be found in the Forms Appendix of this Manual. The use of these age-specific forms aids in capturing all of the required elements in a comprehensive TennCare Kids physical examination.

You must have a process for documenting TennCare Kids services declined by a parent, guardian, or mature competent child. This documentation must include the particular service declined, a notation of the reason why it was declined, and whether another appointment was offered to get the service.

If you are unable to complete all components of a TennCare Kids exam, or if additional questions or concerns remain after a screening, please schedule a follow-up appointment for the child.

Children may receive immunizations at the local health department, rather than in a provider’s office. Administration of the immunization must be included in the chart. The documentation can be a print-out from the health department or from the TN Immunization Information System (TennIIS) or a documented phone call from your office to the health department. The information should include the vaccine administered, site, date, lot number, and any reactions noted. Verbal reporting from a parent or guardian is not adequate confirmation of administered immunizations.

### 3. Developmental Screening Component

Documentation of a TennCare Kids visit should include a description of the developmental behavioral screening method used. When validated developmental screening tests are performed in addition to the preventative medicine service or other services, providers can report CPT code 96110 in addition to the Preventive Medicine Service. Examples listed in CPT include the Denver II and the Early Language Milestones Survey. This service is reported in addition to the Preventive Medicine and other evaluation and management or screening services (hearing, vision, and laboratory) performed during the same visit. Informal developmental checklists are considered part of the history of the preventive medicine visit and not reported and billed separately.

### C. Coordination of Care

UHCCP has care managers available to assist members with special needs, including children with a developed Individualized Education Program (IEP). If you are arranging for the member to obtain vision, dental or mental health/substance abuse care, or transportation, the UHCCP care manager will assist you. To reach a UHCCP care manager, call the Customer Service line at 800-690-1606. Choose the Provider option, enter the Tax ID and specific Member ID, and then choose the Medical Management option.

Each quarter, a list of participating specialists will be mailed to the offices of primary care providers to aid the referral process. If you are unable to arrange a needed referral, contact UHCCP for assistance at 800-690-1606. Choose the Provider option, enter the Tax ID and specific Member ID, and then choose the Medical Management option. Please document any referrals in the child’s chart.
D. Additional TennCare Kids Information

If you would like additional information about TennCare Kids, you can:

- Contact Customer Service at 800-690-1606
- Access the TennCare website at [http://tn.gov/tenncare/section/tenncare-kids](http://tn.gov/tenncare/section/tenncare-kids)
- Reference the TennCare Kids requirements from the Contractor Risk Agreement located on the TennCare website at [http://tn.gov/tenncare/topic/providers-managed-care-organizations](http://tn.gov/tenncare/topic/providers-managed-care-organizations)
XIV. Quality Improvement Program

Quality Management/Quality Improvement (QM/QI) (2.15), addresses physical health, behavioral health, and long-term care services, is evaluated annually and updated as appropriate, using the results of QM/QI activities to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members. The Quality Improvement Program monitors performance in the following areas, including but not limited:

• Access to Care
• Member Satisfaction using Consumer Assessment of Healthcare Providers and Systems (CAHPS)
• Quality of Care/Quality of Service
• PCP and BH provider coordination
• Patient Safety

The QM Department monitors the quality of care delivered to members and the outcomes of treatment through several clinical studies. Another way to monitor the quality of care delivered to members is through direct review of medical records. The QM and Network Services departments review a sample of medical records at least annually. Physicians and other health care providers are notified of the results of the audits with strengths and weaknesses being identified. Corrective Action Plans are required of physicians and other health care providers when performance falls below expected thresholds.

Issues resulting from physicians and other health care provider’s availability, physicians and other health care provider’s non-compliance, or diminished quality of care are forwarded to the UHCCP Chief Medical Officer and/or Medical Director. The reviewer determines an action, and notifies the physician and UHCCP of all such actions. The Peer Review process is strictly confidential. Aggregate results are reviewed by the Provider Affairs Committee and the Quality Management Committee.

A. Provider Participation in Quality Improvement Program

Providers are encouraged to participate with UHCCP in Quality Improvement activities. Our committees that address concerns related to members, providers and UHCCP are enhanced by the ongoing participation of contracted providers. Our committees include Provider Affairs Committee and Quality Management Committee. Providers are encouraged to offer feedback to UHCCP on our various Quality Improvement projects and processes. In addition, UHCCP participating providers have agreed contractually to comply with the UHCCP Quality Improvement Program. The program includes, but is not limited to:

• Ensuring that care is appropriately coordinated and managed between providers and the member’s primary physician
• On-site audits and requests for treatment records as described below
• Cooperation with the member complaint process
• Response to inquiries by the UHCCP Quality Management Committee staff or UHCCP Quality Management staff
• Participation in UHCCP Quality Improvement studies related to enhancing clinical care or service for UHCCP members
• Participation in data collection process for HEDIS® and Medical Record Documentation Review
• Assisting UHCCP in maintaining various accreditations as appropriate and as requested by UHCCP.

Providers can access information about the UHCCP Quality Improvement Program at www.uhccommunityplan.com. UHCCP examines the effect of treatment programs using measures such as, but not limited to, outcome measurement, re-hospitalization rates and drug utilization reviews. Some of the activities involving providers are described in more detail below.

B. Service Initiatives

Information gathered from a variety of sources is used to identify service initiatives for UHCCP. These include but are not limited to complaint and grievance information, appeals and directives information, customer service calls, and member satisfaction surveys. Participating providers must engage in Quality Improvement activities, including service initiatives as they are identified.

C. Member Satisfaction

UHCCP utilizes multiple sources for obtaining member feedback. This includes administration of the annual CAHPS® member satisfaction survey, member complaints/grievances/appeals, member/provider/employee/employer feedback, and information obtained from member service calls. The information is gathered, sorted, and aggregated. Every attempt is made to address the customer’s issue/problem at the time of the occurrence (1st call resolution). In addition, the information is aggregated for tracking and trending. Opportunities, typically service initiatives, are identified and become part of the annual Health Services Work Plan.

D. Member Satisfaction Surveys

On an annual basis, UHCCP conducts a member satisfaction survey of a representative sample of UHC CP members receiving health services. The member satisfaction survey is one tool that UHCCP uses to assess its customers’ satisfaction across three components of care: satisfaction with services, satisfaction with quality, and satisfaction with access. The results of the survey are compared to performance goals, and improvement action plans are developed to address any areas not meeting the standard. Both the survey results and action plans are shared with members, network providers, and TennCare.

E. Quality of Care/Quality of Service Issues

Quality of Care and Quality of Service concerns are member reported or discovered by UHCCP staff and are investigated in collaboration with the Chief Medical Officer or Medical Director. Outcomes of quality issues are reviewed during the credentialing process, as well. If a quality issue has occurred, corrective action may include notifying the provider, education, and request for additional CME education for the provider, probation, summary suspension, or termination. UHCCP has processes in place to report serious deficiencies to the appropriate agencies and/or National Practitioner Data Bank.
F. Provider Satisfaction Surveys

On an annual basis, UHCCP conducts a provider satisfaction survey of a representative sample of providers delivering health services to UHCCP members. This survey obtains data on provider satisfaction with UHCCP’s services including prior authorization and utilization management services, care management, provider services, and claims administration.

G. Internal Staff Compliance Monitoring

In order to measure the accuracy and consistency of the application of health services processes and criteria across UHCCP staff in the home office and operation sites, internal staff compliance monitoring is conducted at least annually for care management, credentialing, appeals, grievances, investigation of member complaints of quality of care/service issues, pharmacy, medical necessity (MN), prior authorization, and member notification of provider termination. Results of the monitoring is aggregated by type of review and analyzed to identify specific issues that may require staff training.

H. Delegation Oversight Process

UHCCP may delegate certain functions of Quality Improvement, Utilization Management, Credentialing, Members Rights, and Medical Records to other entities. The ultimate authority and responsibility for those activities, however, remains with UHCCP.

UHCCP performs continuous oversight of these delegated functions and on an annual basis audits each entity. If deficiencies are discovered, a corrective action plan is requested by UHCCP and agreed upon by both parties. UHCCP staff monitors correction of these deficiencies. UHCCP can reclaim responsibility for the function if correction of deficiencies does not occur. Audit results are sent to the appropriate committee (Credentialing Committee for Credentialing and the Corporate QI Committee for approval or non-approval of the delegation).

I. Patient Safety

Quality medical care is the core of the UHCCP’s mission and Health Services program. As part of that commitment, UHCCP integrates patient safety into the various aspects of the annual Health Services program. The comprehensive focus on patient safety is seen in multiple aspects of UHCCP.

1. Prospective Drug Safety Review – Patient Safety

UHCCP monitors the FDA Center for Drug Evaluation and Review (CDER) for announcements of drug product recalls or drug product safety warnings. The Pharmacy Director and Chief Medical Officer will evaluate the need for action. In general, a need for action exists when:

- A significant safety concern is identified about a pharmaceutical in common use.
- The likelihood exists that without intervention from UHCCP members will continue to use a pharmaceutical with significant risks to their health.
- The safety warning involves information not previously known to members or providers prior to the issuing of the warning.
When such a situation is determined to exist, an immediate plan of action will be determined. This generally involves a review of claims to identify members currently established on the medication with a high likelihood for continued therapy and their prescribing physician. Depending on the urgency of the situation, a decision will be made to notify the members and/or their physicians. Notification may take place through direct mail or scheduled publications (HealthTalk, Provider Update and/or Pharmacy Update), again depending on urgency and publication schedules.

2. Pharmacy Programs – Patient Safety

UHCCP works together with the TennCare Pharmacy Benefit Manager to review patient clinical information, which it can use to optimize each member’s care. Instances may exist whereby pharmacy utilization patterns may require either immediate intervention or detailed investigation and analysis to determine whether clinical issues require intervention. These may be but are not limited to:

- Potential drug disease interactions
- Multiple prescriptions within the same pharmaceutical class (poly-pharmacy)
- Under utilization of medications to treat a specific disease process
- Over utilization of medications to treat a specific disease process
- Utilization of medications in excess of established guidelines
- Suspected uncoordinated health care by multiple providers
- Suspected inappropriate/excessive controlled substance usage
- Suspected fraudulent and/or illegal acquisition of prescription medications

UHCCP monitors the above issues and intervenes as appropriate with either physician or member. Members who display drug-seeking behavior may be placed in a “restricted access” situation.

J. Preventative Behavioral and Physical Health Services

UHCCP selects and designs its preventive health programs based on the demographic, cultural, clinical, and risk characteristics of its members. Providers are enlisted to participate in the design and implementation of preventive health programs. UHCCP will periodically communicate the results and effects of its preventive health programs to providers.

K. Practice Guidelines

UHCCP has adopted clinical guidelines from nationally recognized organizations and groups. In addition, we have some supplemental guidelines that are based on the existing nationally recognized guidelines, additional literature review, and provider input. The development of these supplemental guidelines is driven by quality initiatives aimed at improving clinical outcomes for members. We encourage your feedback on all guidelines and welcome any suggestions on new guidelines to be considered for adoption. See the chapter on Clinical Practice Guidelines in this Manual for more details (Chapter X).
L. Investigation and Resolution of Member Complaints Against Providers

Providers are expected to cooperate with UHCCP in the quality improvement complaint investigation and resolution process. If UHC CP requests written records for the purpose of investigating a member complaint, providers should use their best efforts to submit these to UHCCP within 10 business days. Complaints filed by UHCCP members should not interfere with the professional relationship between the provider and member.

Quality Management staff in conjunction with Network Management staff will monitor complaints filed against all network providers and solicit information from network providers in order to address the member complaints. UHCCP will develop and implement appropriate action plans to correct legitimate problems discovered in the course of investigating member complaints. Such action plans may include the following:

• Require the provider to submit and adhere to a corrective action plan.

• Monitor the provider for a specified period, followed by a determination about whether substandard performance or noncompliance with UHCCP requirements is continuing.

• Require the provider to use peer consultation for specified types of care.

• Require the provider to obtain training in specified types of care.

• Limit the provider’s scope of practice in treating UHCCP members.

• Cease enrolling or referring any new or existing UHCCP members to the care of the provider, or reassign members to the care of another participating provider.

• Temporarily suspend the provider’s participation status with UHCCP.

• Terminate the provider’s participation status with UHCCP.

M. On-site Visits

UHCCP representatives conduct on-site visits with select high volume providers, potential high volume providers prior to credentialing and facilities without national accreditation; as well as random routine audits and to address quality of care issues brought to UHCCP’s attention. During this visit, charts are reviewed for documentation of diagnosis, treatment plan and verification of services provided to UHCCP members. Providers are expected to maintain adequate medical records on all members. Prior to the visit, each provider will be notified of the specific types of charts that will be reviewed. Failure to document services and/or dates of services may lead to a request for a corrective action plan.

Our high volume behavioral health network providers shall develop a working knowledge of and are audited according to the UHCCP Provider Evaluation of Performance (PEP) Plan. The PEP plan and associated audit tools detail minimum requirements from this Manual, provider contracts, Federal and state laws, rules, and regulations, and the National Committee for Quality Assurance (NCQA) accreditation standards. Therefore, UHCCP will conduct site visits at their network provider locations to evaluate the providers’ policies and procedures, as well as records maintained on UHCCP members, to assess compliance with these requirements and work with providers to render quality services in accordance
with these standards. This Provider Evaluation of Performance (PEP) Plan details the content of the audits that will be conducted so providers will have a summary of these requirements they can utilize to review their own performance and conduct agency improvements. To arrange obtaining copies of the PEP plan and audit tools, providers may contact customer service at 800-690-1606 and ask to speak with a member of the Behavioral Health Quality Improvement Department or visit http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-ProviderInformation/TN-BehavioralHealthToolkit.pdf.

N. HEDIS®

HEDIS®, the Healthcare Effectiveness Data and Information Set, is a set of standardized measures collected to show a health plan’s performance in member care. HEDIS® is developed (and updated annually) with the knowledge of clinical and technical experts and the representation of purchasers, members, managed care organizations, providers, and policy makers. HEDIS® focuses much of its attention on the major health issues affecting Americans today. UHCCP analyzes and applies the results from HEDIS® measures when considering Population Health strategies in the areas of asthma, diabetes, cardiovascular disease, women’s care, childhood immunizations, and more. Measures such as Comprehensive Diabetes Care, Use of Appropriate Medications for People with Asthma, Breast Cancer Screening and many others are important tools in care management. The focus of UHCCP is to improve care to its members, which is reflected in our HEDIS® rates. In order to determine the most accurate HEDIS® rates, UHCCP conducts “Hybrid Data Collection”. Hybrid data collection is a combination of administrative data and data found manually by medical record review. A sample of members for each hybrid measure is randomly selected from UHCCP’s population for hybrid chart review. Trained medical abstractors review patient’s charts to obtain necessary documentation relevant to each HEDIS® measure. Hybrid measures include but are not limited to the following:

- Childhood Immunization Status
- Adolescent Immunization Status
- Prenatal and Postpartum Care
- Controlling High Blood Pressure
- Comprehensive Diabetes Care

UHCCP greatly appreciates providers’ efforts in supporting the HEDIS chart review process each year! HEDIS is compiled and submitted to NCQA each June. Following the completion of HEDIS, NCQA publishes a “Report Card” reflecting the rates UHCCP reached on the HEDIS measures. Members and providers may use the UHCCP annual HEDIS results to compare quality across health plans and regions. HEDIS is a part of NCQA’s accreditation program. Accredited plans are required to submit audited HEDIS data annually. NCQA reassesses a health plan’s accreditation status with each year’s HEDIS, and may raise or lower the standing accordingly. Furthermore, NCQA is very interested in seeing improvement in quality of care on an annual basis. UPRV holds Commendable accreditation status from NCQA. For more information about HEDIS, or for a copy of the UHCCP’s latest HEDIS report card, go to www.ncqa.org. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

O. Reporting Abuse and Neglect of Adults

Frail Elderly and Disabled population are vulnerable to abuse, neglect and exploitation. Health care providers are responsible for identifying and reporting suspected cases of abuse, neglect or exploitation. In addition, failure to report child abuse or neglect is a violation of the law. This section outlines the protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 et seq.).
1. Types of Abuse and Neglect

1.1 Passive and Active Neglect

With passive and active neglect the caregiver fails to meet the physical, social, and/or emotional needs of the older person. The difference between active and passive neglect lies in the intent of the caregiver. With active neglect, the caregiver intentionally fails to meet his/her obligations towards the older person. With passive neglect, the failure is unintentional and often is the result of caregiver overload or lack of information concerning appropriate care giving strategies. Signs of passive and active neglect include, but are not limited to:

- Evidence that personal care is lacking or neglected
- Signs of malnourishment (sunken eyes, loss of weight)
- Chronic health problems both physical and/or psychiatric
- Dehydration (extreme thirst)
- Pressure sores (bed sores)

1.2 Physical Abuse

Physical abuse consists of an intentional infliction of physical harm of an older person. The abuse can range from slapping an older adult to beatings to excessive forms of physical restraint (e.g. chaining). Signs of physical abuse include, but are not limited to:

- Overt signs of physical trauma (scratches, bruises, cuts, burns, punctures, choke marks)
- Signs of restraint trauma (rope burns, gag marks, welts)
- Injury - particularly if repeated (sprains, fractures, detached retina, dislocation, paralysis)
- Additional signs - hypothermia, abnormal chemistry values, pain upon being touched
- Repeated "unexplained" injuries
- Inconsistent explanations of the injuries
- Physical examination reveals injuries which the caregiver has failed to disclose
- A history of doctor or emergency room "shopping"
- Repeated time lags between the time of any "injury or fall" and medical treatment

1.3 Psychological Abuse

Psychological or emotional abuse consists of the intentional infliction of mental harm and/or psychological distress upon the older adult. The abuse can range from insults and verbal assaults to threats of physical harm or isolation. Signs of psychological abuse include, but are not limited to:
Psychological Signs:

- Ambivalence, deference, passivity, shame
- Anxiety (mild to severe)
- Depression, hopelessness, helplessness, thoughts of suicide
- Confusion, disorientation

Behavioral Signs:

- Trembling, clinging, cowering, lack of eye contact
- Evasiveness
- Agitation
- Hypervigilance

1.4 Sexual Abuse

Sexual abuse consists of any sexual activity for which the older person does not consent or is incapable of giving consent. The sexual activity can range from exhibitionism to fondling to oral, anal, or vaginal penetration. Signs of sexual abuse include, but are not limited to:

- Trauma to the genital area (bruises)
- Venereal disease
- Infections/unusual discharge or smell
- Indicators common to psychological abuse may be concomitant with sexual abuse

1.5 Material/Financial Abuse

Material and financial abuse consists of the misuse, misappropriation, and/or exploitation of an older adult’s material (possessions, property) and/or monetary assets. Signs of material/financial abuse include, but are not limited to:

- Unusual banking activity (large withdrawals during a brief period of time, switching of accounts from one bank to another, ATM activity by a homebound elder)
- Bank statements (credit card statements, etc.) no longer come to the older adult
- Documents are being drawn up for the elder to sign but the elder cannot explain or understand the purpose of the papers
- The elder’s living situation is not commensurate with the size of the elder’s estate (lack of new clothing or amenities, unpaid bills)
• The caregiver only expresses concern regarding the financial status of the older person and does not ask questions or express concern regarding the physical and/or mental health status of the elder.

• Personal belongings such as jewelry, art, furs are missing.

• Signatures on checks and other documents do not match the signature of the older person.

• Recent acquaintances, housekeepers, "care" providers, etc. declare undying affection for the older person and isolate the elder from long-term friends or family.

• Recent acquaintances, housekeeper, caregiver, etc. make promises of lifelong care in exchange for deeding all property and/or assigning all assets over to the acquaintance, caregiver, etc.

1.6 Violations of Basic Rights

Violations of basic rights is often concomitant with psychological abuse and consists of depriving the older person of the basic rights that are protected under state and Federal law ranging from the right of privacy to freedom of religion. Signs of violations of basic rights include, but are not limited to:

• Caregiver withholds or reads the elder’s mail.

• Caregiver intentionally obstructs the older person’s religious observances (dietary restrictions, holiday participation, visits by minister/priest/rabbi).

• Caregiver has removed all doors from the older adult’s room.

• Indicators common to psychological abuse may be concomitant with basic rights violations.

1.7 Self Neglect

The older person fails to meet their own physical, psychological, and/or social needs. Signs of self neglect include, but are not limited to:

• Person is unable to complete the processes/steps needed of daily living (obtain and prepare food, care for personal hygiene, obtain and retain running water, obtain and retain electricity/gas/heat).

• Person is unable to keep personal dwelling free from hazards (pests or rodents, extreme clutter, structural damage to include holes in floors, outside walls, and/or roofing).

1.8 Other Examples of Abuse and Neglect

• Elder is not given the opportunity to speak without the caregiver being present.

• Caregiver exhibits high levels of indifference or anger towards the older adult.

• Over medication or over sedation.
2. Risk Factors for Abuse

There are certainly various risk factors that increase the likelihood that an individual will be a victim of abuse or neglect. Risk factors for abuse and neglect include, but are not limited to:

- Spouses make up a large percentage of elder abusers. Partnerships where one member of a couple has tried to exert power over the other can be vulnerable.
- Abusers are often dependent on their victims for financial assistance, housing, and other forms of support.
- Abusers who live with the elder have more opportunity to abuse and may at the same time be isolated from the community and may seek to isolate the elder from others.
- Well intended caregivers are so overwhelmed by the burden of caring for dependent elders that they sometimes end up striking out, neglecting, or harming the elder.
- Personality characteristics of the elder such as dementia, disruptive behaviors, and significant needs for assistance may place the elder at increased risk.

3. How to Report Abuse

3.1 Reporting by Phone or Fax

As required by Tennessee state law, you must report any suspected or confirmed cases of abuse or neglect. To report abuse or neglect, please call:

Adult Protective Services: 888-APS-TENN (888-277-8366)

You can also report suspected or confirmed cases of abuse or neglect after hours by fax:

Adult Protective Services After Hours Intake Fax: 866-294-3961

Reporting is confidential.

3.2 Emergency Reporting

If the individual is at immediate risk, please call 911.

P. Reporting Abuse and Neglect of Children

According to Tennessee law, all persons (including doctors, mental health professionals, child care providers, dentists, family members and friends) must report suspected cases of child abuse or neglect. Failure to report child abuse or neglect is a violation of the law. Child abuse and neglect occurs when a child is mistreated, resulting in injury or risk of harm. Abuse can be physical, verbal, emotional or sexual. This section outlines the protocols for preventing, identifying, and reporting suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 et seq. and TCA 37-1-601 et seq.).

1. Types of Abuse and Neglect

1.1 Physical Abuse is non-accidental physical trauma or injury inflicted by a parent or caretaker on a child. It also includes a parent's or a caretaker's failure to protect a child from another person who perpetrated physical abuse on a child. In its most severe form, physical abuse is likely to cause great bodily harm or death.
1.2 **Physical Neglect** is the failure to provide for a child’s physical survival needs to the extent that there is harm or risk of harm to the child’s health or safety. This may include, but is not limited to abandonment, lack of supervision, life-endangering physical hygiene, lack of adequate nutrition that places the child below the normal growth curve, lack of shelter, lack of medical or dental that results in health-threatening conditions, and the inability to meet basic clothing needs of a child. In its most severe form, physical neglect may result in great bodily harm or death.

1.3 **Sexual Abuse** includes penetration or external touching of a child’s intimate parts, oral sex with a child, indecent exposure or any other sexual act performed in a child’s presence for sexual gratification, sexual use of a child for prostitution, and the manufacturing of child pornography. Child sexual abuse is also the willful failure of the parent or the child’s caretaker to make a reasonable effort to stop child sexual abuse by another person.

1.4 **Emotional Abuse** includes verbal assaults, ignoring and indifference or constant family conflict. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker.

2. **Possible Indicators of Abuse and Neglect**

2.1 **Indications from the Child**

The below signs indicate that something is wrong, but they do not necessarily point to abuse. However, if you notice these signs early, you may be able to prevent abuse or neglect.

- The child has repeated injuries that are not properly treated or adequately explained
- The child acting in unusual ways ranging from disruptive and aggressive to passive and withdrawn
- The child acts in the role of parent towards their brothers and sisters or even toward their own parents
- The child may have disturbed sleep (nightmares, bed wetting, fear of sleeping alone, and needing a nightlight)
- The child loses his/her appetite, over eats, or may report being hungry
- There is a sudden drop in school grades or participation in activities
- The child may act in stylized ways, such as sexual behavior that is not normal for his/her age group
- The child may report abusive or neglectful acts

2.2 **Indications from the Parent**

Parents who abuse or neglect their children may show some common characteristics:

- Possible drug/alcohol history
- Disorganized home life
- May seem to be isolated from the community and have no close friends
- When asked about a child’s injury, may offer conflicting reasons or no explanation at all
- May seem unwilling or unable to provide for a child’s basic needs
• May not have age appropriate expectations of their children
• May use harsh discipline that is not appropriate for child’s age or behavior
• Were abused or neglected as a child

3. How to Report Abuse

As required by Tennessee state law, you must report any suspected or confirmed cases of abuse or neglect. When reporting suspected or confirmed abuse, be prepared to give the name of individual, address, age, telephone number, and specifics of abuse.

3.1 Reporting by Phone

Child Protective Services: 877-237-0004

Calls are confidential.

3.2 Reporting Online

A secure website (https://reportabuse.state.tn.us/) is available for you to report suspicions of abuse/neglect of children when the suspected abuse/neglect took place in Tennessee. This reporting system is provided for your convenience to report instances of abuse or neglect that do not require an emergency response.

3.3 Emergency Reporting

If the individual is at immediate risk, please call 911.

Q. Behavioral Health Provider Adverse Occurrence/Sentinel Event Reporting

A Behavioral Health Provider Adverse Occurrence is a serious or unexpected occurrence involving a member, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a member receiving inpatient, residential treatment center or crisis stabilization unit services, and that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services. Examples of an adverse occurrences include:

• Suicide death;
• Suicide attempt with significant medical intervention requiring an emergency room visit or inpatient hospital stay;
• Homicide;
• Homicide attempt with significant medical intervention requiring an emergency room visit or inpatient hospital stay;
• Allegations of abuse/neglect (physical, sexual, verbal) including peer to peer;
• Death-cause unknown;
• Medical emergency (i.e.: heart attack, medically unstable, etc.);
• Accidental injury with significant medical intervention requiring an emergency room visit or inpatient hospital stay;
• Use of restraints/seclusion (physical, chemical, mechanical) with significant medical intervention while the member is in the care of a behavioral health inpatient, residential or crisis stabilization unit;
• Treatment complications (defined as medication errors and adverse medication reaction) with significant medical intervention requiring an emergency room visit or inpatient hospital stay;
• Elopement (specific to inpatient and residential services only, as related to minors or involuntary admissions for adults

Adverse Occurrence reports must be reported by Behavioral Health network providers to all appropriate agencies as required by licensure and state/Federal laws within one business day following the event. Adverse Occurrence reporting forms are available on the provider website at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-AdverseOccurrenceForm.pdf.
XV. Coverage of Abortion, Sterilization, Hysterectomy (ASH)

UHCCP shall cover Abortion, Sterilization, and Hysterectomy pursuant to applicable Federal and State laws and regulations. The Bureau of TennCare has given all MCOs a list of minimum codes that must be reviewed for possible abortions, sterilizations, or hysterectomies. If the claim has one of these ‘suspect’ codes, please submit medical records detailing the procedure with the claim. This will facilitate faster claims payment. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions, with the original form maintained in the member’s medical file and a copy submitted to UHCCP. A copy of the current list of codes that are reviewed for abortions, sterilizations, and hysterectomies follows this section. Please note that these may change, and an updated version is maintained on the UHCCP website. Required forms for abortions, sterilizations, and hysterectomies are available in the Forms Appendix of this Manual and on the UHCCP website at http://www.uhccommunityplan.com/health-professionals/tn/provider-information.

A. Abortions

1. General Guidelines

Under the Hyde Amendment, UHCCP is permitted to provide reimbursement for abortions only when one of the following circumstances is present:

• There is credible evidence to believe the pregnancy is the result of rape or incest.

• The abortion is medically necessary because the mother suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

• Please see the Forms Appendix of the Manual for a copy of this form.

2. Instructions for Completing the Certification of Medical Necessity (CMN) for Abortion

• Date: The date the abortion was performed. This can be typed or handwritten.

• Patient’s Full Name: The name of the member can be typed or handwritten.

• Patient’s Social Security Number: The member’s Social Security number can be typed or handwritten.

• Condition: Mark the block indicating the applicable reason for the abortion. This can be typed or handwritten.

• Supporting Documentation: Mark the block that applies to the type of supporting documentation. This can be typed or handwritten.

• Patient Address: Include the member’s complete address. This can be typed or handwritten.

• Physician Signature: The physician MUST sign his/her name in his/her own handwriting.

• Physician Name, Social Security Number, and Address: The physician’s name, Social Security number, and complete address can be typed or handwritten.
B. Sterilizations

1. General Guidelines

Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

• The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than 72 hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of sterilization.

• The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.

• The individual to be sterilized is mentally competent.

• The individual to be sterilized is not institutionalized (not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed).

• The individual has voluntarily given informed consent on the approved “STERILIZATION CONSENT FORM”, MEDICAID FORM TDH-603.

• A copy of the signed consent form must be attached to the claim form.

• Photocopying of the form is allowed. Please see the Forms Appendix of the Manual for a copy of this form.

2. Instructions for Completing the Sterilization Consent Form

Top Right Corner

• **Recipient Medicaid Number:** The member’s TennCare Identification Number may be typed or handwritten.

Part 1: Consent to Sterilization

• **(Doctor or Clinic):** The physician’s name, group name, or clinic name from whom the member received information about the sterilization procedure can be typed or handwritten.

• **Type of Sterilization Operation:** The type of operation to be performed on the member can be typed or handwritten.

• **(Month, Day, Year):** The member’s date of birth can be typed or handwritten. The member must be twenty-one (21) years old to sign the sterilization form.

• **Member Name:** The member’s name can be typed or handwritten.

• **(Doctor):** Physician’s name, group name, or clinic (if the member is not sure who will be performing the sterilization procedure) can be typed or handwritten. The physician listed in this blank does not have to be the same physician who performed the procedure.

• **Type of Sterilization Procedure:** The type of procedure to be performed can be typed or handwritten.
• **Signature of Recipient:** The member must sign his/her name and date in his/her own handwriting. If the member cannot sign his/her name he/she can make his/her mark “X” in member’s signature if there is a witness. The witness must sign below his/her name and write the date they witnessed the member make their mark. This must be in the witness’ own handwriting. The witness should write “witness” beside his/her name.

• **Date:** The member must write the date he/she signed the consent form in their own handwriting when signing the consent form.

• **Time Signed:** The member should write in the time they signed the consent form.

• **Race and Ethnicity Designation:** This field is optional.

• **Language Use to Explain Consent Form:** If an interpreter is used, the language can be typed or handwritten.

• **Signature of Interpreter:** The interpreter must sign his/her name. If an interpreter is not used, write N/A in the blank.

• **Date:** The interpreter must write the date in his/her own handwriting simultaneously to signing the form. If an interpreter is not used, write N/A in the blank.

**Part 2: Statement of Person Obtaining Consent**

• **Name of Individual:** The name of member to be sterilized can be typed or handwritten.

• **Type of Sterilization Operation:** The type of operation to be performed on the member can be typed or handwritten.

• **Signature of person obtaining consent:** The person who obtained consent must simultaneously sign and date the consent form in his/her own handwriting prior to surgery. The signature of the person obtaining consent must be signed prior to surgery.

• **Date:** The person who obtained consent must simultaneously sign and date the consent form in his/her own handwriting prior to surgery. The date must be written prior to surgery.

• **Facility:** The name of the facility where the person obtaining consent is located can be typed or handwritten.

• **Address:** The address of the facility can be typed or handwritten.

• **Name of the individual to be sterilized:** The member’s name can be typed or handwritten.

• **Date of sterilization:** The exact date the sterilization was performed can be typed or handwritten. The date of service on the claim requesting payment must be the same date on the sterilization consent form.

  — Thirty calendar days must have lapsed between the date the member signed the consent form and the date the sterilization procedure was performed. Start counting day one (1), the day after the member signs the consent form. Then, the sterilization can be performed on the 31st day except in the case of premature delivery or emergency abdominal surgery.

  — In case of premature delivery, at least 72 hours must have passed between the day and the time the member signed the consent form before the sterilization procedure can be performed. At least thirty (30) calendar days...
would have had to lapse between the dates the member signed the consent form and the individual’s expected date of delivery.

— In the case of emergency abdominal surgery, at least 72 hours must have passed between the day and the time the member signed the consent form before the sterilization procedure can be performed.

— The consent form expires 180 calendar days from the date of member’s signature. Start counting the date the member signed the consent form as day one (1). The procedure must be performed within 180 calendar days.

* Specific type of operation: The type of operation can be typed or handwritten.

* Alternative Final Paragraph:

— Cross-out paragraph two (2) if at least thirty (30) calendar days have lapsed between the date of the members signature on the consent form and the date the sterilization operation was performed.

— Cross out paragraph one (1) if this sterilization was performed less than thirty (30) calendar days but more than 72 hours after the date of the member’s signature on the consent form because of premature delivery or emergency abdominal surgery. Check appropriate boxes for premature delivery and individual expected date of delivery and fill in the member’s expected date of delivery. If emergency abdominal surgery, check appropriate box and describe circumstances.

* Physician’s Signature: The physician who performed the sterilization procedure must sign his/her name and date he/she signed the consent form simultaneously in his/her own handwriting. The physician must sign the consent form after surgery. The physician’s signature, date, and time must be in his/her own handwriting. Typed or stamped signatures, initials, or dates are not acceptable.

— If the physician signs the consent form the same day as surgery then he/she must specify what time he/she signed the consent forms.

— If the physician signs the consent form the same day as surgery and signs the time he/she signed the consent form as 8:00 a.m. or earlier, the time surgery ended must be specified below on the consent form.

— If the physician signs the consent form the day after surgery or later then the time the physician signed the consent form may be left blank.

C. Hysterectomy

1. General Guidelines

Hysterectomy shall be covered when medically necessary.

• The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.

• A copy of the signed consent form, Medicaid Form TDHE-605, must be attached to the claim form.
• Informed consent must be obtained regardless of diagnosis or age. Please see the Forms Appendix of the Manual for a copy of this form.

• Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.

• Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

• Hysterectomy shall not be covered if it was performed for the purpose of cancer prophylaxis.

2. Instructions for completing the Hysterectomy Acknowledgment Form

Part 1: General Information—Always complete in entirety

• Recipient Name: The member’s name can be typed or handwritten.

• Medicaid ID No.: The member’s TennCare ID number can be typed or handwritten.

• Physician’s Name: The Physician’s name can be typed or handwritten.

• Date of Hysterectomy: The date the hysterectomy was performed can be typed or handwritten.

Part 2: Section A—Complete for Member who acknowledges receipt prior to hysterectomy

• Witness Signature and Date: The witness must sign his/her name and date in his/her own handwriting prior to surgery. If the patient is already sterile or this is an emergency (life-threatening) procedure, go to Section B.

• Patient’s Signature and Date: The patient must sign her name and date in her own handwriting prior to surgery. If the patient cannot sign her name, she can make her mark “X” in patient’s signature blank if there is a witness. The witness must sign below his/her name and simultaneously date the day they witnessed the recipient make their mark. This must be in the witness’ own handwriting. The witness should write witness beside their name.

If Section A has been completed, STOP HERE.

Part 3: Section B—Complete when any of the Exceptions listed below are applicable.

• Box 1: This box is checked only if the member was approved retroactively. A copy of the UHCCP member ID card, which covers the date of the hysterectomy, or a copy of the retroactive approval notice, must accompany this form before reimbursement can be made.

• Box 2: This box is checked if the patient was already sterile prior to surgery. The cause of sterility must be described and can be typed or handwritten.

• Box 3: This box is checked if the patient had a hysterectomy performed because of a life-threatening situation and the information concerning sterility could not be given prior to the hysterectomy. The emergency situation must be described and can be typed or handwritten.

• Physician Signature and Date: The physician must sign his/her name and date simultaneously in his/her own handwriting.
Part 4: Section C—Complete for Mentally Incompetent Member

- **Witness Signature and Date:** The witness must sign his/her name and date in his/her own handwriting prior to surgery.

- **Patient’s Signature and Date:** The patient must sign her name and date in her own handwriting prior to surgery.

- **Reason for Hysterectomy:** The reason for hysterectomy must be described and can be typed or handwritten.

- **Physician Signature and Date:** The physician must sign his/her name and date simultaneously in his/her own handwriting after surgery.

D. Documentation Required for Claim Payment

1. **Abortions Absolute**
   - State Medical Necessity Form
   - Documentation (police report, STMT from Rape Crisis Center) to support necessity form

2. **Abortions Suspect or Missed**
   - Ultrasound report or physician’s documentation of ultrasound report
   - History and physical (documentation of ultrasound, history of bleeding, open OS, etc)
   - Operative report
   - Pathology report

3. **Sterilization Absolute**
   - Sterilization Consent Form

4. **Hysterectomy Absolute**
   - Hysterectomy Acknowledgement Form
   - Documentation of medical necessity, if not provided and approved prior to the procedure

5. **Tips to Avoid Denials for ASH Services**
   - Ensure that the consent form is legible, including the printed text, and not just the signature section. Copies of copies are often illegible.
   - Submit the state-approved consent forms, not a facility or practice consent form.
   - Include member ID on the submission.
   - Member must be 21 or older at the time of consent to sterilization.
   - Ensure all required signatures (member, witness, and physician) are provided, including date/time
• The interpreter’s statement must either be completed or marked N/A.
• Cross out the final paragraph which does not apply.
• Date of service on the consent form must match the service date on the claim.
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A. Credentialing Application and Policies

The Credentialing Program includes the credentialing of physicians and other health care professionals. Contracted providers must be credentialed prior to providing services to TennCare members. Non-contracted providers must be credentialed when used on a frequent basis.

In situations where UHCCP delegates credentialing to entities such as an IPA, PHO or other managed care organization, the contracted provider must comply with the UHCCP credentialing requirements.

The credentialing program consists of both practitioner and organizational provider credentialing and re-credentialing. UHCCP conducts primary source verification and reviews the application and attestation form(s). Through its credentialing/re-credentialing process, UHCCP staff conducts facility site visits upon initial credentialing, when applicable, and will conduct follow up site visits. The UHCCP credentialing committee reviews the information obtained from the complete application, primary source verification, and site visits, as well as other information, to make credentialing/re-credentialing decisions. Please note: a Complete Application means: 1) The application form is complete and necessary additional explanations provided; 2) all requested attachments have been submitted; 3) verification of the information is complete; and 4) all information necessary to properly evaluate the applicant’s qualifications has been received and is consistent with the information provided in the application. The complete application is then ready for review by the Credentialing Committee. Organizational credentialing involves credentialing of hospitals, ambulatory surgical centers, home health/infusion agencies, skilled nursing facilities, and urgent/walk in clinics. Re-credentialing occurs on a triennial basis.

Following submission of a complete application, education, training, licensing, Criminal Attestation, Disclosure of Ownership and Control Interest Statement, and malpractice insurance, the information must be verified prior to the Credentialing Committee’s review. This process, including Credentialing Committee review, must be completed before a provider is authorized to provide services to a UHCCP member. Plan approval (or denial) is communicated, in writing, to each provider who makes an application with UHCCP within thirty (30) calendar days of receiving the complete application.

1. Non-discrimination in Network Participation

UHCCP does not deny or limit the participation of any clinician or facility in the UHCCP network, and/or otherwise discriminate against any clinician or facility based solely on any characteristic protected under state, Federal, or local law.

UHCCP wishes to assure its clinicians and facilities that it has never had a policy of terminating a clinician or facility because he or she: (1) advocated on behalf of a member; (2) filed a complaint against UHCCP; (3) appealed a decision of UHCCP; or (4) requested a review or challenged a termination decision.

UHCCP has not, and will not, terminate any clinician or facility from its network based on any of the four grounds enumerated above. Nothing in UHCCP’s clinician or facility contracts should be read to contradict or in any way modify this long-standing practice.

2. Public Release of Physician/Clinician Specific Information

UHCCP does not release any individual clinician-specific utilization management information to entities outside of UHCCP except as permitted or required by law.
3. Written Notification and Correction of Information

If, during the process of credentialing or re-credentialing, UHCCP discovers information that varies substantially from that which was initially provided, UHCCP will notify the clinician or facility and offer an opportunity to correct the information. Clinicians and Facilities are given 10 business days to respond. Responses must be made in writing to UHCCP. Once the corrected information is verified, it becomes part of the clinician’s or facility’s file and is maintained in the same manner as all other credentialing and re-credentialing material.

Clinicians or Facilities have the right to:

- Review information submitted to support their credentialing application
- Correct erroneous information
- Be informed of their credentialing and re-credentialing status, upon request
- Be informed of their rights

Please note, it is required as part of your contract that you provide updated demographic information as changes occur.

4. Credentialing Process for Medical Providers

The UHCCP credentialing/re-credentialing process is completed by our National Credentialing Center (NCC). Applications are retrieved from the Council for Affordable Quality Healthcare (CAQH) website. First time applicants will need to contact the National Credentialing Center (VETTS line) at 877-842-3210 to obtain a CAQH number in order to complete the application online.

UHCCP uses the Universal Provider Data Source®, developed by the Council for Affordable Quality Healthcare, to obtain the data needed for credentialing and re-credentialing of our network clinicians, and many clinicians who are contracted with us through a group practice, unless otherwise required by law. The CAQH web-based credentialing tool streamlines the credentialing process by enabling you to complete your credentialing application online. This free service for healthcare professionals is available 24 hours a day, 365 days a year. The online application allows you to save your work and return later to finish the process. Once completed, CAQH stores the application online and enables you to make updates to your information as needed. By keeping your CAQH information current, future re-credentialing is quick and easy.

The following supporting documents must be submitted to CAQH upon completion of the application:

- Curriculum Vitae
- Medical license
- DEA certificate
- Malpractice insurance face sheet
- IRS Form W-9
5. Credentialing Process for Behavioral Health Providers

5.1 Clinician Network Development and Maintenance

UHCCP is responsible for arranging for the provision of a comprehensive spectrum of behavioral health services for our members. Our clinician network consists of licensed qualified professionals from the disciplines of psychiatry, psychology, psychiatric nurse practitioners, clinical social work, and licensed counselors. Our panel also includes an array of facility-based programs that offer all levels of services to UHCCP members. We believe our clinicians and our facilities are the keys to our success and we work hard to maintain a mutually beneficial partnership.

5.2 Behavioral Health Clinical Credentialing

The success of UHCCP depends on the clinical experience and expertise of our participating clinicians. To ensure that our members receive the highest quality clinical treatment, our participating clinicians are credentialed according to rigorous criteria that reflect professional and community standards. These criteria include, but are not limited to, satisfaction of the following standards:

- Independent Licensure or certification in your state(s) of practice, except as required by applicable state law
- License is in good standing and free from restriction and/or without probationary status
- Disclosure of Ownership Statement
- Board Certification or Board Eligibility (to complete prior to the recredentialing cycle) for psychiatrists
- Current certification through the Federal Drug Enforcement Agency (DEA) for prescribing clinicians in each state in which they practice.
- Professional Liability Coverage: a minimum of $1 million occurrence/$1 million aggregate for master’s level and doctoral-level clinicians and a minimum of $1 million/$3 million for physicians (exceptions to these required insurance amounts may be made as required by applicable state law)
- Free from any exclusion and debarment from government programs

UHCCP has specific requirements for identified specialty areas. These specialty areas include: Masters’ level license professionals, such as LCSW’s, LPC’s, LMFT’s, and SLPE’s, Employee Assistance Professionals, Substance Abuse Professionals, and Certifications in Critical Incident Stress Debriefing. If you request recognition of a specialty area, an attestation statement must be signed noting the specific criteria met for the given specialty. Current competency is randomly audited to ensure that the network remains active and up to date in their specialty fields. We have adopted a Credentialing Plan to address the requirements for participation and the events justifying disciplinary action, including termination of participation.

Once your application is completed with CAQH, UHCCP may utilize Aperture, an NCQA certified Credentials Verification Organization (CVO), to review the application packet for completeness and collect any missing or incomplete information.
5.3 Behavioral Health Clinician Unavailable Status

In order to enhance network access for UHCCP members and practice convenience for participating clinicians, we offer clinicians the ability to list themselves as temporarily unavailable for new referrals. Some common reasons for requesting unavailable status are extended illness, vacation plans and lack of available appointments. Should you need to request unavailable status, it is best to notify us of your lack of availability for referrals as soon as possible, but at most within 10 calendar days of the date you become unavailable. Participating clinicians may remain unavailable for any period of time not to exceed six months. It is your responsibility — and to our mutual advantage — to notify UHCCP plan when you are once again available for referrals. Participating clinicians who have been on unavailable status for five months will receive a letter reminding them to contact UHCCP. Failure to contact UHCCP within 30 calendar days of the date of the reminder letter may result in the termination of your clinician agreement. Please note that all contractual obligations continue while on unavailable status, including continuity of care requirements being met for members already in services with the participating clinicians and compliance with the Grier Consent Decree. Changes in availability status may be addressed by contacting your Provider Advocate.

B. Re-credentialing Process

1. Physical Health Provider Re-credentialing

All providers are re-credentialed every three years. At the time of re-credentialing, the UHCCP credentialing department will provide the provider with a pre-populated application and forms for review and updating. The provider’s professional license, DEA license (if applicable), new Criminal Attestation and Disclosure of Ownership and Control Interest Statement, and professional liability insurance are verified prior to the Credentialing Committee review. Each provider’s file is also reviewed for any sanctions and debarments (UHCCP and/or State/Federal) and quality of care or quality of service issues. This triennial cycle does not preclude re-credentialing for shorter time frames due to quality issues and/or per the direction of the Corporate Credentialing Committee.

2. Behavioral Health Clinician Re-credentialing

In accordance with our commitment to the highest quality of clinical treatment, we re-credential clinicians every 36 months unless state law dictates a different re-credentialing cycle. During re-credentialing, you will be required to provide a current copy of your DEA certificate (if applicable) in addition to a current copy of the following:

- Professional licensure and/or certification
- Federal Drug Enforcement Agency (DEA) certificate (if applicable) for each state in your practice
- W-9
- Professional and general liability insurance
- Curriculum vitae

You may also be asked to:
• Attest to your areas of clinical specialty and appropriate training supporting the identified specialties

• Sign a release of information granting access to information pertaining to your professional standing and any records there of. This is required for primary source verification. The signed release will allow UHCCP to contact any professional society, hospital, insurance company, present or past employer or other entity, institution or organization that does or may have information pertaining to your professional standing. Failure to provide such a release will preclude completion of your re-credentialing and prevent your continued participation in the network.

You are required to provide a copy of all professional documents whenever such document renew or change.

**C. Organization Provider Credentialing Program**

The success of UHCCP depends on the clinical competency and expertise of our participating facilities. In order for our members to receive the highest quality clinical treatment, our participating facilities are credentialed according to rigorous criteria that reflect professional and community standards.

UHCCP follows the guidelines of NCQA regarding the credentialing of facilities, programs, and clinicians. As part of the credentialing and re-credentialing process, facilities are required to submit documentation supporting their professional and community standing and defining their program offerings. This documentation includes, but is not limited to:

• Current copies of all licenses required by your state for the services you offer

• Current copies of accreditation certificate and/or letter

• General and professional liability insurance certificates

• W9 forms

• Signed malpractice claims statement/history

• Staff roster, including attending physicians

• Daily program schedules

• Program description

In the event your facility is not accredited by an agency recognized by UHCCP, a site audit will be required prior to credentialing and again prior to re-credentialing. Please refer to your Facility Participation Agreement for details regarding your obligations to notify UHCCP specific to malpractice claims made against your facility. The UHCCP Credentialing Plan addresses the requirements for participation and the events justifying disciplinary action, including termination of participation.
XVII. Medical Record Review

UHCCP annually reviews randomly selected PCP medical records to measure compliance to industry and UHCCP standards. Providers who are not in compliance with these standards are notified of their specific deficiencies. Results are used to determine opportunities for improvement and implement appropriate interventions. Primary care is defined as the following specialties: Family Practice, Pediatrics, Internal Medicine, Obstetrics/Gynecology, or Geriatrics. However, as provided in Section 2.11.2.4 of the CRA, in certain circumstances other physicians may be primary care physicians if they are willing an able to carry out all PCP responsibilities.

Medical records should be comprehensive and maintained in a current, detailed, organized manner which permits effective and confidential patient care and quality review as well as administrative, civil, and/or criminal investigations and/or prosecutions. Records should reflect all aspects of a patient’s care. Records should be maintained or be available at the site where covered services are rendered. Records are to be stored securely with access given only to authorized personnel. Information from the medical records review may be used in the re-credentialing of providers.

In order to perform utilization management and quality improvement activities, UHCCP may request access to such records, including claims records. The Federal, state and local government, or accrediting agencies, may also request such information necessary to comply with accreditation standards, statutes, or regulations applicable to UHCCP or providers. As a condition of participation with the TennCare program, all members give access permission to their medical records to UHCCP, TennCare, and applicable oversight institutions. No further permissions are needed.

All records shall be maintained in accordance with the most stringent standards contained in HIPAA, ARRA (EHR/Electronic Health Records) requirements, CRA Section 2.24.6 and TCA Title 33. Members (for purposes of behavioral health records, member includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the members' medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges, (except as detailed below) be given copies there of upon request. In the event a patient/provider relationship ends and the member requests that medical records be sent to a different provider, the first provider shall not charge the member or the second provider for providing the medical records.

A. Physical Health Medical Record Review Standard Guidelines

1. Organization of the Medical Record

   • Neatly Arranged & Legible: Contents of the record should be arranged in a manner which facilitates the easy retrieval of pertinent clinical information and be legible by individuals other than the writer. The pages of the medical record should be secure and held in place with a fastener.

   • Provider Identification: All entries to the progress notes, including dictated notes and vital signs flow sheet, should identify who saw the patient and authored the notes. Author identification may be a handwritten signature, unique electronic identifier or initials. All non-physician providers will note their professional title. Mid level provider notes should be co-signed by the supervising physician if required by Tennessee state law.

   • Dated Entries: All entries entered into the medical record should be dated.

   • Patient Information: Patient name is required on each page in the record. Each page must contain the patient name. There should only be one medical record per patient. The contents of each record should be specific to one individual patient.
• **Patient Demographics:** All patient charts should contain the patient’s date of birth, sex, current address, employer, home/cellular and work telephone numbers, and marital status. If the information is not placed in the chart, it must be available for review. (The information may be run off the office computer system.)

2. **Medical Record Content**

• **Allergies/Adverse Reactions:** Allergies and/or adverse reactions to medications should be prominently noted on the record. If no known allergies, note “NKA”.

• **Past Medical, Surgical, Family/Social for All Patients Seen Three (3) or More Times:** To include documentation of history, all past and current (past 3 years) medical illnesses, family history of medical conditions, and conditions at the time the history is taken. Also include any serious accidents, surgeries or illnesses. For children and adolescents (18 years and younger), past medical history will relate to prenatal care, birth, operations, and childhood illnesses in addition to the family and social history. History and current status of smoking should be documented in a central location and/or recent progress note. It should include past history of smoking, current status of smoking and when advised to quit in the past year for anyone 12 years and older and who has been seen at least 3 times. Document Substance Abuse and ETOH use/abuse in a central location and/or recent progress note for history and current status of substance abuse and ETOH for anyone 12 years and older and who has been seen at least 3 times. Medications and dosages of all current medications (prescription and over-the-counter) taken by the patient should be recorded in a central location or the most recent progress note.

• **Pelvic Exams:** The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. Findings on pelvic exam as well as PAP results must be documented in the medical record. Referral(s), if indicated, must be documented as well.

• **X-ray, Lab, & Other Procedure Results:** All ancillary reports (laboratory, X-Ray, PT, consultations, etc.) should be reviewed and initialed by the provider who ordered them, indicating his or her review of the report. Abnormal results are mentioned in the progress notes. The request-to-procedure time should be consistent with clinical urgency, but no greater than 14 calendar days for routine services and no greater than 48 hours for urgent services.

• **Progression Note Documentation:** Should include the reason for member’s visit, history of current illness and physical exam documentation, including vital signs if appropriate, all should be documented in the progress note.

• **Diagnostic Impression:** The progress note should reflect a diagnosis consistent with findings.

• **Treatment Plan:** The provider’s treatment or plans for further evaluation, as well as appropriate member education, should be clearly outlined. This would include tests completed or ordered, medications prescribed with dosing, therapies and other prescribed regimens, and any consults to occur. There should be evidence that this was discussed with the patient and that the patient was given the opportunity to participate in the development of treatment plan to extent possible. The patients understanding of and agreement with the treatment plan should be noted.

• **Follow-up Note, Plans for Continuing Care:** The provider’s plans for either the present complaint or for general health maintenance should be noted in the progress note and be consistent with clinical need. This would include weeks, months, or treatment as needed.

• **Clinical Tools/Flowsheets for Patients with Chronic Conditions:** The record should contain practice guidelines, prescription printouts with safety guidelines, flowsheets for monitoring labs, etc.
3. Continuity of Care

- **Problem List:** Persistent/chronic problems should be documented on a current problem list. The list should be kept current and contain information within the past 3 years (36 consecutive months).

- **Consultant/Referral Reports:** All consultants, referral reports, and corresponding ancillary reports should be filed in the chart.

- **Timely Transfer of Medical Records:** Medical records should be transferred timely (within 48 hours) to other locations and providers.

- **Documentation of Preventative Services:** Age appropriate preventative services should be performed in accordance with HEDIS guidelines. Documentation of follow-up for abnormal results should be present in the record.

- **Documented Follow up of Abnormal Cervical or Breast Cancer Screenings:** When cervical or breast cancer screening has been performed during the review, there should be documentation of follow-up for abnormal results.

- **Discharge Summaries:** All discharge summaries should be filed in the chart.

- **Emergency Room Summaries:** All emergency room summaries should be filed in the chart.

- **EPSDT Standards & Childhood Immunizations:** Immunization status should be centrally located in each chart. All basic immunizations should be recorded. For members under 21 years old, who are enrolled in the TennCare Kids program, immunizations should be given at the time of the EPSDT preventive/checkup visit or at any other contact with the child. The schedule for administration of immunizations should follow the Recommended Childhood Immunization Schedule from the American Academy of Pediatrics and the Centers for Disease Control Advisory Committee on Immunization Practices. Pediatric charts should reflect compliance with EPSDT standards for wellness exams and screenings.

- **Advance Directives:** The Patient Self Determination Act requires that patient records (charts) note whether or not an advance directive has been made. A notation that the provider has addressed advance directives (whether or not the patient has executed an advance directive) should be present in a prominent part on adult member charts. An adult member is defined as 18 years and older. For behavioral health services, the above noted documentation regarding advanced directives in addition to the use of Declarations for Mental Health Treatment under TCA Title 33, Chapter 6, Part 10 should be present in a prominent part of all member charts ages 16 and older.

- **Appropriate Use of Consults:** Document the appropriate and timely use of consults. The request to appointment time should be consistent with clinical urgency, but no greater than 21 calendar days.

4. Confidentiality of Medical Records

- **Safeguards of Records:** The patient files are maintained in a secure area, which is monitored by the office staff and is not freely accessible to the public. Medical records should be stored in an organized fashion for easy retrieval in a designated area.

- **Staff Confidentiality Training:** There is written documentation such as a signed policy or initials on an orientation checklist that shows office staff is aware of medical record confidentiality policies.
• **Release of Information:** There is a policy requiring the patient’s signature on a Release of Information Form.

• **Record Retention:** There is a policy that identifies the length of time to retain medical records consistent with State and Federal regulations

**5. Member Access**

• Members are able to schedule an appointment for an urgent problem within 48 hours.

• Members are able to schedule an appointment for a wellness exam within 3 weeks.

• Members are able to schedule an appointment for a routine exam within 2 weeks.

• Response time for after hours calls are within 15 minutes or as soon as possible.

• Providers should have a process for monitoring and addressing missed appointments.

**B. Medical Records Standards for TennCare Kids (EPSDT) Examinations**

Medical records will be reviewed regularly for compliance with TennCare Kids standards. It is expected that all medical records containing a TennCare Kids (EPSDT) examination be in complete compliance with the requirements detailed in this chapter. Should a patient refuse a TennCare Kids (EPSDT) exam or treatment or any portion of the exam or treatment, the provider should document that refusal in the medical record. To assist with your TennCare Kids chart documentation, the Tennessee Chapter of the American Academy of Pediatrics has developed age specific screening review forms. These recommended forms can be found in the Forms Appendix. The TennCare Kids medical records standards and requirements include the following:

**1. Comprehensive Health and Developmental History**

• **Past Medical/Social History (documented at least once):** This would include documentation of the member’s medical conditions including any surgeries and accidents. This would include documentation of the member’s social, mental and developmental history. This would include smoking, alcohol and drug use for patients 12 years or older. This information is helpful in assessing "at risk" individuals. This must be documented at least once in the medical record.

• **Family History (documented at least once):** This would include documentation of the medical, mental, and social history of family members (parents, grandparents, aunts, uncles, and siblings). Pay particular attention to documentation of family history of heart disease, TB, and socioeconomic factors. This information is helpful in assessing "at risk" individuals. This must be documented at least once in the medical record.

• **Current Problems Identified:** This would include documentation of any medical, social, and mental problems identified during the interval of time since documentation of the initial personal history or any current medical, social, and mental problems identified at this visit.

• **Allergies Identified or NKA noted:** Medication allergies and/or adverse reactions should be prominently noted on the record. If there are no known allergies, NKA must be documented.
2. Comprehensive Assessment

- **Developmental Assessment (age appropriate):** Assessment includes a range of activities to determine whether an individual's developmental processes falls within a normal range of achievement according to age group and cultural background. Elements include, but not limited to, assessment of fine and gross motor skills, communication skills, self-help and self-care skills, social-emotional development, and cognitive skills. There should be up-to-date growth and developmental charts for children ages birth through 20 years. All information collected during the assessment should be documented in the medical record.

- **Nutritional Assessment:** Assessment includes documentation of dietary practices to identify unusual eating patterns such as pica, extended bottle-feeding, and/or obesity.

- **Lead Risk Assessment (6 months to 72 months):** All children age 6 months to 72 months are considered “at risk” and must be screened for lead poisoning at each visit. The provider must ask a series of questions to determine the level of risk. If the child is considered low risk, the child should have a blood lead screening at 12 months and 24 months of age. If the child is considered at high risk a blood lead screening should be performed at the current visit and every visit thereafter as long as the child is assessed at high risk. CMS now requires the use of the blood lead test when screening children for lead poisoning. The erythrocyte protoporphyrin test is no longer acceptable as a screening test for lead poisoning. All information collected during the assessment should be documented in the medical record.

- **Dyslipidemia Risk Assessment:** Assessment should begin at age two. The assessment should include documentation in the medical record of a parent or grandparent with coronary or peripheral vascular disease before age 55, parent with elevated blood cholesterol and/or a child with risk factors for future coronary disease (physical inactivity, obesity, diabetes mellitus).

3. Health Screening

- **Vision Testing (age appropriate):** Vision screenings should be age appropriate based on the periodicity schedule. They may be subjective through the age of three years by questioning the caregiver. After age three years, a standard testing method should be used. The United States Preventive Services Task Force (USPSTF) recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors. The child should be referred to optometrists/ophthalmologists as needed.

- **Hearing Testing:** Hearing screenings are based on the periodicity schedule. The child should be referred to an audiologist, as needed.

4. Comprehensive Unclothed Physical Exam

- **General Physical Exam:** The uncloth ed physical exam should include documentation of the child's general physical appearance to determine overall health status and pick up obvious physical defects. The exam should include evaluation of all body systems, i.e. heart, lung, gastrointestinal, skin, nervous system. An exam of the oral cavity and teeth should also be documented. Documentation must state "unclothed exam."

- **Height:** The child's height should be documented at each visit.

- **Weight:** The child's weight should be documented at each visit.
5. Pediatric Health Care Recommendations

Bright Futures and American Academy of Pediatrics recommendations for Preventative Pediatric Health Care can be found at: [http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf](http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf)

6. Health Education Discussion

Age appropriate health education should be documented at each visit and should include anticipatory guidance. Health education and counseling to the caregiver and child is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of a healthy lifestyle, as well as accident and disease prevention.

7. Continuity of Care

- **BMI**: The BMI is to be performed beginning at age 2 and every year through 21 years. Patients, ages 2 through 18 years, must have documentation of BMI percentile measurement or a BMI percentile measurement plotted on an age growth chart and counseling for nutrition and physical activity. Patients ages 19 years and older must have documentation of BMI measurement value.

- **Blood Pressure**: The child’s blood pressure should be documented at each visit starting at age 3 years.

- **Head Circumference**: The child’s head circumference should be documented at each visit through the age of three years.

- **Comprehensive Developmental/Behavioral Screening**: Early identification of children with developmental disabilities leads to effective therapy of those conditions for which definitive treatment is available. A range of activities is evaluated to determine whether an individual's developmental processes fall within a normal range of achievements according to age group and cultural background. If findings appear abnormal, these children should be referred to an appropriate diagnosis/treatment provider for further evaluation and/or treatment. Documentation of developmental/behavioral screening must be documented in the medical record. Referrals, if indicated, must also be documented in the medical record.

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7. Continuity of Care

• **Appropriate Documentation of Referrals and Follow-up**: All referrals to specialists should be documented and any follow-up carried out. There may be documentation of referrals to WIC (Women, Infants, & Children), Head Start, or other private and public resources.

• **Dental Referral (age 3 years or greater)**: Documentation of dental inspection, referral and education must be documented in the medical record. A direct dental risk assessment and referral is recommended for every child in accordance with the periodicity schedule. Referral by the primary care physician or health provider has been recommended based on risk assessment, as early as 6 months of age, 6 months after the first tooth erupts, and no later than 12 months of age. If medically necessary, a child may be referred at any age. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home.
If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation. Dental examinations by a dentist should occur more frequently (every six months) than is the case with physical examinations. Therefore, it is important that the provider educates the child and/or caregiver to the importance the dental health and documents the referral to a dentist.

8. Laboratory Testing

- **HCT/HGB:** There should be documentation of a screening blood test for iron deficiency. Hematocrit or hemoglobin screening should be performed once between the ages of 9 and 12 months, the preferred age being 9 months, and at any time the child is at risk during the ages of 15 months to 5 years. Hematocrit or hemoglobin testing should be performed once during ages 11-20 with the preferred age being 13. In addition, all girls post-menarche should have a test performed annually. If the test is administered any other time than those ages listed above, document in medical record.

- **Urinalysis:** There should be documentation of a minimum of one (1) urinalysis or dip stick urine at 11 thru 20 years, and yearly if sexually active.

- **Newborn Screen/PKU:** Coverage is provided for the treatment of PKU, including licensed professional medical services and special dietary formulas. There should be documentation of a newborn screening and PKU at time of birth. The newborn screening includes tests for hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia. Newborn screening and PKU at the time of birth should be documented if the child is twelve months old or less at the time of this exam.

- **Sickle Cell (one time only):** Diagnosis for sickle cell trait may be done with sickle cell preparation or hemoglobin solubility test. If a child has been properly tested once for sickle cell disease, the test need not be repeated. This measure is applicable at all ages.

- **Lead (Low Risk Screening):** All children receiving an EPSDT exam are considered at risk for lead toxicity. Blood lead tests are required at 12 and 24 months of age. Children ages 36 to 72 months should be tested if they were missed earlier.

- **Lead (High Risk Screening):** A blood lead test is required when a child is identified as being high risk, beginning at six months of age. If the initial blood lead test results are less than five micrograms per deciliter (ug/dL), a screening blood lead test is required at every visit through 6 years of age, unless the child has already received a blood test within the last six months. A blood lead test result equal to or greater than 5 ug/dL obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample. If the test occurs at 6, 12 or 24 months, mark the appropriate box on the audit form. If the child had the test at a different age, document in the medical record. The medical record must contain laboratory report of test results. Diagnosis, education, and follow-up should be documented in the medical record.

- **Tuberculosis (TB) Screening and Testing:** Testing should be performed upon recognition of high risk factors in accordance with the most current edition of the Red Book: Report of the Committee on Infectious Diseases. The TB Risk Assessment Questionnaire should be completed at EPSDT screening exams at age 1, 4, 12, 18 and 24 months and 3-21 years or at any point that the child is at risk for contracting TB.
• **Dyslipidemia Screening (at risk):** The following AAP Guidelines provide specific recommendations for selective screening of children and adolescents in the context of their continuing care. The most current recommendation is to screen children and adolescents with a positive family history of dyslipidemia or premature (<55 years of age for men and <65 years of age for women) CVD. It is also recommended that pediatric patients for whom family history is not known or those with other CVD risk factors, such as overweight (BMI >85th percentile, <95th percentile), obesity (BMI >95th percentile), hypertension (blood pressure >95th percentile), cigarette smoking, or diabetes mellitus, be screened with a fasting lipid profile. For these children, the first screening should take place after 2 years of age but no later than 10 years of age. Screening before 2 years of age is not recommended.

• **STI: All sexually active adolescents should be tested annually for Sexually Transmitted Infections, or more often if considered medically necessary. Sexually Transmitted Infections testing and results must be documented in the medical record along with education, discussion and/or treatment. Local health departments must be notified of positive Sexually Transmitted Infections testing. UHCCP provides for one annual chlamydia screening test in conjunction with an annual Pap smear for females who are not more than 29 years of age, if deemed medically necessary.

• **Immunizations Verified Up To Date for Appropriate Age:** The schedule for administration of immunizations should follow the Recommended Childhood Immunization Schedule from the American Academy of Pediatrics and the Centers for Disease Control Advisory Committee on Immunization Practices. Immunizations should be reviewed and administered at appropriate ages, or as needed.

• **Requirement to use participating laboratories:**
  This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals except as indicated in the following two bullets:

  • This protocol does not apply where the physician bears financial risk of laboratory services.
  • This protocol does not apply to laboratory services provided by physicians in their offices.

We maintain a robust network of regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the UnitedHealthcare network. Participating laboratories also provide clinical data and related information to support HEDIS reporting, care management, the UnitedHealth Premium Designation program and other clinical quality improvement activities. It is important to note that in many benefit plans, Customers receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses.

You are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a Payer. Participating laboratory providers can be found in the UnitedHealthcare Physician Directory online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com). If you need assistance in locating or using a participating laboratory Provider, please contact UnitedHealthcare Network Management.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UnitedHealthcare in advance to confirm that the specific laboratory test is covered. We will work with you to assure that those covered tests are performed, even if that means the use of a non-participating laboratory.
• **Administrative actions for out-of-network laboratory services referrals**

UnitedHealthcare network physicians have long demonstrated their commitment to affordable health care by making extensive use of participating laboratories. We anticipate that virtually all participating physicians will be able to easily find a participating laboratory that will meet their needs.

If we identify an ongoing and material practice of referrals to out-of-network laboratory service providers, we will inform the responsible participating physicians of the issue and remind them that physicians in the UnitedHealthcare network are generally required by contract to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:

- Loss of eligibility for the Practice Rewards programs;
- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

• **Self-Referral and Anti-Kickback**

This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals. Referrals for laboratory services that results in the physician earning a profit, including, but not limited to the following, are not allowed:

- Profits resulting from an investment in an entity for which the referring physician or health care professional generates business; or
- Profits resulting from collection, processing and/or transport of specimens.
- Failure to comply with this protocol may result in
- Decreased fee schedule, or

Termination of network participation as provided in your agreement with us.

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C. Behavioral Health Treatment Record Documentation Requirements

In accordance with the behavioral health provider agreement, providers are required to maintain high quality medical, financial, and administrative records related to behavioral health services that they provide. These records must be maintained in a manner consistent with the standards of the community, conform to all applicable statutes and regulations, and included under Behavioral Health Record Content Requirements.
1. Behavioral Health Record Content Requirements

UHCCP expects that all treatment records will at a minimum include:

- Each record may be on paper or in electronic format
- Each page in the treatment record contains the member's name or identification number
- Each record contains the member's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms, and guardianship information, if relevant.
- All entries in the treatment record are dated and include the responsible clinician’s name, professional degree, license, and relevant identification number, if applicable.
- The record is in blue or black ink, legible to someone other than the writer, and maintained in a current, detailed, organized, and comprehensive manner.
- All modifications made to treatment records are done in a uniform manner. Any error is to be lined through so that it can still be read, then dated, and initialed by the person making the change.
- Medication allergies, adverse reactions, and relevant medical conditions are clearly documented and dated. If the member has no known allergies, history of adverse reactions, or relevant medical conditions, this is prominently noted.
- Presenting problems, relevant psychological and social conditions affecting the member’s medical and psychiatric status and the results of a mental status exam are documented and the source of such information is listed.
- Each member who has executed a Declaration of Mental Health Treatment should have a copy of the form in a prominent place within their record. More information on and copies of the Declaration of Mental Health Treatment form can be found on the state website at http://www.tn.gov/assets/entities/behavioral-health/attachments/Declaration_for_Mental_Health_Treatment-Form.pdf. This form can also be found in the Forms Appendix of this Manual.
- Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised as appropriate. It is also important to document the absence of such conditions.
- Each record indicates what medications have been prescribed, the dosage of each, and the dates of initial prescription or refills. Informed consent for medication and the member’s understanding of the treatment plan are documented. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For members 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
2. Behavioral Health Assessment Requirements:

Members shall have comprehensive assessments of their physical and mental health status at the time of admission to services that includes:

- A psychiatric assessment which includes: description of the presenting problem, psychiatric history and history of consumer’s response to crisis situations, psychiatric symptoms, multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM), mental status exam, and history of alcohol and drug abuse;

- A medical assessment that includes: screening for medical problems, medical history, present medications, and medication history

- A substance use assessment that includes: frequently used over-the-counter medications, alcohol, and other drugs, and history of prior alcohol and drug 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 consumer’s functioning in the following domains: living arrangements, daily activities (vocational/educational), social support, financial, leisure/recreational, physical health, and emotional/behavioral health

- An assessment of consumer strengths, current life status, personal goals, and needs

All assessment documentation should be included in the member’s record.
3. Individualized Treatment Plans

Individualized treatment plans should be consistent with diagnoses based on the comprehensive assessments previously mentioned, have both objective, measurable goals, and estimated timeframes for goal attainment or problem resolution, and include a preliminary discharge plan. Individualized treatment plans should be included in the member’s record.

- Individualized treatment plans must be completed for any consumer 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 necessary based on the consumer’s progress towards goals or a significant change in psychiatric symptoms, medical condition, and/or community functioning.

- Documentation that the consumer, and as appropriate, his/her family members or legal guardian, participated in the development and subsequent reviews of the treatment plan is required.

- 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 consumer.

- The treatment plan must contain the following elements:
  - Identified problem(s) for which the consumer is seeking treatment
  - Consumer goals related to problem(s) identified
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes, but is not limited to, 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 in resolving crisis; and the consumer’s preferred treatment options, to include psychopharmacology, in the event of a mental health crisis.
4. Continuity of Care

- Continuity and coordination of care activities between the primary provider, consultants, other behavioral health and medical providers and health care institutions should be included in the member’s record. If the member refuses to allow you to communicate with their other care providers, this must be documented.

- Referrals to other providers, services, community resources and/or wellness and prevention programs are documented when applicable.

- All correspondence regarding the member’s treatment and signed and dated notations of telephone calls regarding the member’s treatment shall be included.

- Progress notes should describe member strengths and limitations in achieving treatment plan goals and objectives as well as reflect treatment interventions that are consistent with those goals and objectives. Dates for follow-up or complete termination summaries shall be included.

- A brief discharge summary must be completed within 15 calendar days following discharge from services or death. Discharge summaries for psychiatric hospital or residential treatment facility admissions that occur while the member is receiving behavioral health services shall also be documented.

5. Guidelines for Storing and Maintaining Behavioral Health Treatment Records

Below are additional guidelines for completed and maintaining treatment records for members:

- Practice sites must have a record review process to assess the content of the consumer records for legibility, organization, completion, and conformance to standards listed above.

- Practice sites must have an organized system of filing information in treatment records.

- Treatment records must be stored in a secure area and the practice site must have an established procedure to maintain the confidentiality of treatment records in accordance with any applicable statutes and regulations.

- The practice site must have a process in place to ensure that records are available to qualified professionals if the treating professional is absent.

- All records shall be maintained in accordance with the most stringent standards contained in HIPAA requirements and TCA Title 33.

- Members (for purposes of behavioral health records, member includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the members’ medical records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges, (except as detailed below) be given copies there of upon request.

- Provisions for ensuring that, in the event a patient-provider relationship with a TennCare PCP ends and the member requests that medical records be sent to a second TennCare provider who will be the member’s primary care provider, the first provider does not charge the member or the second provider for providing the medical records.
Behavioral Health Clinical Supervision of Non-licensed Clinicians

UHCCP expects that ongoing supervision will be provided by Mental Health/Substance Abuse facility/CMHA providers who employ non-licensed clinical staff. The facility should ensure that all non-licensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the non-credentialed clinician to review the treatment and/or services provided to members.

• Supervision must be clinical in nature
• Supervision must be documented and kept on file
• Up to two (2) multi-disciplinary staffings or group supervision meetings may be counted for two (2) in-person supervision sessions per month
• All supervision of non-licensed clinicians must be completed by a licensed clinician.

UHCCP will conduct audits to ensure compliance with clinical supervision expectations.
A. Introduction to Pharmacy Benefits Manager

TennCare has implemented a statewide Preferred Drug List (PDL) for the pharmacy program that is the same for all members, no matter which managed care organization they are enrolled. TennCare has employed a single Pharmacy Benefits Manager (PBM) to process all TennCare pharmacy claims and respond to all prior authorization requests. TennCare’s PBM is Magellan. Services covered by Magellan include medications and any DME items picked up at the pharmacy, such as diabetic supplies and asthma related items like spacers and peak flow meters. Any medications provided by specialty pharmacy providers directly to provider offices will be prior authorized/reimbursed through Magellan. Pharmacy prior authorization forms, the current PDL, prior authorization criteria, and the current Automatic Exemption and Attestations Lists can be found on the website at: https://tenncare.magellanhealth.com/.

B. Contacting the Pharmacy Benefits Manager

Contact information for Magellan

Prior Approval/Clinical  Phone: 866-434-5524 or Fax: 866-434-5523
Pharmacy Help Desk  Phone: 866-434-5520
Member Inquiries  Phone: 888-816-1680

C. UHCCP Reimbursement for Injectable Medications

UHCCP shall be responsible for reimbursement of injectable medications obtained in an office/clinic setting and to providers providing both home infusion services and the drugs and biologics. UHCCP shall require that all professional claims contain NDC (National Drug Code) 11-digit number and unit information to be paid for home infusion and codes. The NDC number must be entered in 24D field of the CMS-1500 Form or the LIN segment of the HIPAA 837 electronic form. Some injectable medications may require prior authorization.
A. Non-Emergency Medical Transportation

1. Introduction to Non-Emergency Medical Transportation (NEMT)

If a TennCare member needs a ride to the doctor, dentist, pharmacy, or other place for their covered health services, they have non-emergency transportation benefits. These non-emergency transportation benefits are for TennCare covered services only. Providers, members or their representatives can schedule the ride for the member. For DCS members, the member’s DCS liaison, foster parent, adoptive parent or provider can make requests for non-emergency medical transportation services on behalf of the member. Transportation services can be accessed 24 hours a day, 7 days a week, 365 days a year.

The UHCCP transportation call center will manage all non-emergent transportation services. Therefore, when a call is made to schedule a ride for a member, the UHCCP transportation call center will work with the transportation providers to ensure that a ride is ready for the member. For trip scheduling or any inquiries regarding non-emergent transportation, please call 866-405-0238.

2. Ambulatory Transportation

Non-Emergency Ambulance Transports – Non-emergency ambulance transportation should be scheduled through the UHCCP transportation call centers. A Certificate of Medical Necessity must be provided when scheduling the transport. The Certificate of Medical Necessity forms can be found in the Forms Appendix of this Manual and online at:


Routine Ambulatory Transportation – Routine ambulatory transportation should be scheduled at least seventy-two (72) hours before the non-emergency medical transportation is needed. This timeframe does not apply to urgent trip requests. Hospital discharges are considered urgent requests. The above timeframe is a basic guideline, and the transportation company must provide or arrange transportation within timeframes required for the health and safety of the member.

B. NEMT Services

The following section discusses NEMT services; however, additional information from this Manual applies to NEMT providers, including the description of the TennCare program, requirements for claims submissions, reporting encounter data, payment policies, information on member appeal rights, member rights and responsibilities, and the provider complaint system.

In the event that a NEMT provider needs to contact UHCCP directly, please call Customer Service at 800-690-1606. If Customer Service is unable to address the situation, request escalation to a Transportation Specialist.
1. NEMT Benefits

Non-emergency medical transportation services are necessary non-emergency transportation services provided to convey members to and from TennCare SM covered services (see Section D of this chapter, NEMT Service Definitions). Non-emergency transportation services shall be provided in accordance with Federal law and the Bureau of TennCare’s rules and policies and procedures. TennCare covered services include services provided to a member by a non-contract or non-TennCare provider if:

- the service is covered by Tennessee’s Medicaid State Plan or Section 1115 demonstration waiver,
- the provider could be a TennCare provider for that service, AND
- the service is covered by a third party resource.

If a member requires assistance, an escort may accompany the member; however, only one (1) escort is allowed per member. Except for fixed route and commercial carrier transport, UHCCP shall not make separate or additional payment to a NEMT provider for an escort. Covered NEMT services include having an accompanying adult ride with a member if the member is under age eighteen (18). Except for fixed route and commercial carrier transport, UHCCP shall not make separate or additional payment to a NEMT provider for an adult accompanying a member under age eighteen (18).

UHCCP is not responsible for providing NEMT for any service that is being provided to the member through a HCBS waiver. Mileage reimbursement, car rental fees, or other reimbursement for use of a private automobile is not a covered NEMT service. If the member is a child, transportation shall be provided in accordance with TennCare Kids requirements.

2. Transportation for Minor Children

NEMT services shall not be denied due to a blanket policy regarding the member’s age or lack of accompanying adult. Any decision to approve transportation of a minor child will be based on the member’s age and/or presence of an accompanying adult. Such decisions will be made on a case-by-case basis and shall be based on the individual facts surrounding the request and State of Tennessee law. Tennessee recognizes the “mature minor exception” to permission for medical treatment.

3. Prior Authorization

All NEMT services must be prior authorized by UHCCP’s transportation call center agent. The call center agent can be contacted by members, providers, or other persons acting on behalf of the member, at the 866-405-0238.

NEMT authorizations must be submitted on claims for service in order to be reimbursed. If a member’s condition requires non-emergency ambulance transportation, door to door, and/or hand to hand service, the member’s treating provider must complete a certificate of Medical Necessity (CMN). The CMN must be on file in order for the prior authorization to be issued.
C. NEMT Vehicle Requirements

All NEMT vehicles must meet or exceed Federal, local, state, and UHCCP requirements along with the manufacturer’s safety, operating, mechanical, and maintenance standards. In addition to being compliant with Federal, local, and state requirements, each applicable NEMT vehicle must be equipped with and/or meet the following guidelines:

- The number of persons in the vehicle, including the driver, will not exceed the vehicle manufacturer’s approved seating capacity;
- Adequately functioning heat and air-conditioning systems;
- Clean, functioning, and accessible seat belts for each passenger seat position. All vehicles will have an easily visible interior sign that states, “All passengers shall use seat belts.” The seat belts will be stored off the floor when not in use;
- Child safety seats in accordance with the state law;
- At least two (2) seat belt extensions;
- At least one (1) seat belt cutter that is kept within easy reach of the driver for emergency situations;
- Functioning interior light within the passenger compartment;
- Accurate, operating speedometer and odometer;
- Two (2) exterior rear view mirrors, one (1) on each side of the vehicle;
- Interior mirror for monitoring the passenger compartment;
- The exterior must be clean and have no broken mirrors or windows, excessive grime, major dents, or paint damage that detract from the overall appearance of the vehicle;
- The interior must be clean and have no torn upholstery, floor, or ceiling covering; damaged or broken seats; protruding sharp edges; dirt, oil, grease or litter; or hazardous debris or unsecured items;
- All vehicles must be smooth riding, so as not to create any passenger discomfort;
- All vehicles must have the NEMT provider’s business name and telephone number decaled on at least both sides of the exterior of the vehicle. The business name and phone number shall appear in lettering that is a minimum of three inches in height and of a color that contrasts with its surrounding background;
- To comply with confidentiality requirements, no words can be displayed on the vehicle that implies that TennCare members are being transported. The name of the NEMT provider’s business must not imply that TennCare members are being transported;
- The vehicle license number and the NEMT provider’s toll-free phone number must be prominently displayed on the interior of each vehicle. This information and the complaint procedures will be clearly visible and available in written format (English and Spanish) in each vehicle for distribution to members upon request;
• Current inspection sicker issued by UHCCP on the outside of the passenger side rear window in the lower right corner;

• Visible interior sign that states, “No Smoking”. Smoking is prohibited in all vehicles at all times;

• All vehicles will carry a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms;

• First aid kid stocked with antiseptic cleansing wipes, triple antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex or other impermeable gloves, and sterile eyewash;

• A current map of all applicable geographic areas with sufficient detail to locate members and provider addresses;

• Regulation size Class B chemical type fire extinguisher. The fire extinguisher must have a visible, up-to-date inspection tag or sticker showing a current inspection of the fire extinguisher by appropriate authority within the past twelve (12) months. The extinguisher must be mounted in a bracket and located in the driver’s compartment and be readily accessible to the driver and passenger(s);

• “Spill kit” that includes liquid spill absorbent, latex or other impermeable gloves, hazardous waste disposal bags, disinfectant, scrub brush, and deodorizer;

• Emergency triangles;

• Each vehicle that is required to stop at all railroad crossings must have a railroad crossing decal that states the vehicle stops at all railroad crossings; and

• A real-time link, two-way radio or telephone. Pagers are not acceptable as a substitute.

All vehicles transporting members with disabilities must comply with applicable requirements of the Americans with Disabilities Act (ADA), including the accessibility requirements for transportation vehicles.

Any NEMT vehicle used to cross a state’s border must comply with all applicable Federal, State of Tennessee and/or other state, and local requirements.

All vehicles that provide stretcher transport must be owned and operated by an entity licensed by the Tennessee Department of Health (DOH) to provide invalid services, have an active valid permit issued by DOH as a ground invalid vehicle, and comply with DOH’s requirements.

All ambulances except those permitted by State of Tennessee law, must be owned and operated by an entity licensed by DOH to provide ambulance services, have an active valid ambulance permit from DOH, and comply with all DOH’s standards and requirements.

Annually, a comprehensive inspection of all NEMT providers’ vehicles will be conducted, with the exception of fixed route vehicles, invalid vehicles, ambulances, or vehicles for NEMT providers with which UHCCP does not have a provider agreement. Upon completion of a successful inspection, an inspection sticker will be applied to the vehicle. The inspection sticker shall be placed on the outside of the passenger side rear window in the lower right corner. The sticker shall state the license plate number and vehicle identification number of the vehicle.
Any NEMT vehicle that does not comply with all standards and requirements will be immediately removed from service. The vehicle that is not in compliance will be out-of-service until it is made to be within the standards and requirements set by UHCCP and the State of Tennessee in order to avoid liquidated damage assessments.

D. NEMT Driver Requirements

All non-emergency medical transportation drivers must meet or exceed the requirements below:

- All drivers shall be courteous, patient, and helpful to all passengers.
- All drivers shall be neat and clean in appearance.
- No driver shall use alcohol, narcotics, illegal drugs, or prescription medications that impair the ability to perform while on duty. No driver shall abuse alcohol or prescription medications or use illegal drugs at any time.
- All drivers shall wear and have visible an identification badge that is easily readable and identifies the driver and the NEMT provider.
- No driver shall smoke or eat while in the vehicle, while assisting a member, or in the presence of any member.
- Drivers shall not wear any type of headphones at any time while on duty, with the exception of hands-free headsets for mobile telephones. Mobile telephones may only be used for communication with the NEMT provider, the dispatcher, or UHCCP.
- Drivers shall exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle.
- The driver shall provide an appropriate level of assistance to a member when requested or when necessitated by the member’s mobility status or personal condition. This includes curb-to-curb, door-to-door, and hand-to-hand service, as required.
- The driver shall assist members in the process of being seated including the fastening of seat belts, securing children in properly-installed child safety seats, and properly securing passengers in wheelchairs.
- The driver shall confirm, prior to departure, that all seat belts are fastened properly, and that all passengers, including passengers in wheelchairs, are safely and properly secured.
- Upon arrival at the destination, the driver shall park the vehicle so that the member does not have to cross the streets to reach the entrance of the destination. Drivers shall visually confirm that the member is inside the destination.
- The driver shall not leave a member unattended at any time.
- If a member or other passenger’s behavior or any other condition impedes the safe operation of the vehicle, the driver shall park the vehicle in a safe location out of traffic, notify the NEMT provider/dispatcher, and request assistance.

Any non-emergency medical transportation driver that does not comply with all standards and requirements will not be allowed to transport UHCCP members until the above criteria are fully met.
E. NEMT Service Definitions

- **Commercial Carrier Transport**: Transportation provided by a common carrier, including but not limited to buses (Greyhound), trains (Amtrak), airplanes and ferries.

- **Curb-to-Curb Service**: Transportation provided to passengers who need little if any assistance between the vehicle and the door of the pick-up point or destination. The driver shall provide assistance according to the member’s needs, including assistance as necessary to enter and exit the vehicle, but assistance shall not include the lifting of any member. The driver shall remain at or near the vehicle and not enter any buildings.

- **Door-to-Door Service**: Provided to members with disabilities that need assistance to safely move between the door of the vehicle and the door of the passenger’s pick-up point or destination. The driver shall exit the vehicle and assist the member from the door of the pick-up point (residence), accompany the passenger to the door of the vehicle, and assist the passenger in entering the vehicle. The driver shall assist the member throughout the transport and to the door of the destination.

- **Federal Motor Carrier Safety Administration (FMCSA)**: A separate administration within the United States Department of Transportation established pursuant to the Motor Carrier Safety Improvement Act of 1999. Its primary mission is to reduce crashes, injuries, and fatalities involving large trucks and buses.

- **Fixed Route**: Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops. Fixed route transportation includes, but is not limited to, non-commercial buses, commuter trains, and trolleys.

- **Hand-to-Hand Service**: Transportation of a member with disabilities from an individual at the pickup point to a provider staff member, family member, or other responsible party at the destination.

- **Hospital Discharge**: Notification by a hospital that a member is ready for discharge. A hospital discharge shall be considered an urgent trip.

- **HRAs: Human Resource Agencies**: These agencies are the delivery system for human services, including transportation to rural residents, throughout the State of Tennessee. The nine HRAs are: Delta HRA, East Tennessee HRA, First Tennessee HRA, Mid-Cumberland HRA, Northwest HRA, South Central Development District, South West HRA, Upper Cumberland HRA, and South East HRA.

- **No-Show**: A trip is considered a no-show when the driver arrived on time, made his/her presence known, and the member is not present five (5) minutes after the scheduled pick-up time.

- **Private Automobile**: An member's personal vehicle or the personal vehicle of a family member or friend, to which the member has access. Private automobile is not a covered NEMT service.

- **Single Trip**: Transport to and/or from a single TennCare covered service. A trip generally has at least two (2) trip legs but there can be one (1) or more than two (2) (multiple) trip legs.

- **Standing Order**: Transport to and/or from multiple recurring medical appointments for TennCare covered services for the same member with the same provider for the same treatment or condition (can be one (1) or multiple trip legs).
• **TennCare Covered Services**: The healthcare services available to TennCare members, as defined in TennCare rules and regulations. This includes, but is not limited to, physical health, behavioral health, pharmacy, and dental services managed through MCOs however provided by entities that are not MCOs. TennCare covered services includes TennCare Kids services.

• **Tennessee Department of Intellectual and Developmental Disabilities (DIDD)**: The state agency responsible for providing services and supports to Tennesseans with mental retardation. DIDD is a division of the Tennessee Department of Finance and Administration.

• **Trip Leg**: One-way transport from a pick-up point to a destination. A trip generally has at least (2) trip legs.

• **Urgent Trip**: Covered NEMT services required for an unscheduled episodic situation in which there is no immediate threat to life or limb but the enrollee must be seen on the day of the request (can be one (1) or multiple trip legs). A hospital discharge shall be an urgent trip.

**F. NEMT Billing Guidelines**

All NEMT providers are subject to the billing requirements outlined within this Manual. NEMT providers are required to obtain authorization prior to any trips by contacting the appropriate transportation Call Center. The transportation Call Center is responsible for issuing an authorization to be used for billing purposes. Once the authorization is obtained, the transportation Call center will send the required manifest to the NEMT provider. All NEMT providers must bill claims using appropriate coding including destination modifiers. NEMT claims should be billed electronically. NEMT providers may also use provider E-Services solutions to check claims status and request claims reviews.
XX. CHOICES Long Term Services and Supports Program

A. Introduction

The TennCare CHOICES Long Term Services and Supports Program is a Medicaid long-term delivery system which fully integrates traditional Long Term Services and Supports (LTSS), nursing facility based services, with Home and Community Based Services (HCBS). This integration ensures a full continuum of services for Medicaid members through a Managed Care Organization (MCO). The Bureau of TennCare now fully integrates these services into the MCO and no longer directly administrates these valuable services.

The collective goals of the CHOICES LTSS Program include:

- Rebalance services between LTSS nursing facility services and HCBS
- Improve access to and utilization of cost-effective HCBS alternative services
- Improve accountability by ensuring that LTSS/HCBS services are provided based on documented functional deficit need
- Improve continuity of care between acute physical healthcare, behavioral health, and LTSS/HCBS services
- Serve more people with rebalancing savings

These goals can be accomplished through the systematic process of assessment, planning, coordinating, implementing, and evaluating a member’s care by care coordination. Fully integrated care coordination ensures that the recipient’s acute/chronic physical health care, behavioral health care, and LTSS/HCBS are provided in a seamless, cohesive, and collaborative manner reducing waste, duplication, and redundancy in services. Care coordination not only provides the recipient with a concierge to facilitate scheduling and service access; it also provides the recipient with an advocate that assists the member in gaining needed knowledge of services and alternatives to make the most informed decision related to health care and custodial services.

B. CHOICES Eligibility and Enrollment

1. Recipients New to Both TennCare and CHOICES

The Tennessee Area Agencies on Aging and Disability (AAAD) is the Bureau of TennCare’s designated Single Point of Entry (SPOE) for recipients new to both TennCare and CHOICES. The AAAD intake staff is responsible for evaluating the reasonable expectation that an individual’s medical/behavioral health and LTSS/HCBS needs can be adequately met in the recipient’s place of residence by the CHOICES Program. If the determination is made that the individual does not qualify for CHOICES, the potential member shall be informed of the right to appeal in compliance with TennCare Rule 1200-13-13-.11.

Providers can refer an individual for the CHOICES Program by calling the AAAD in the individual’s area. See table below of nine AAAD statewide offices.
<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Counties Include</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First Tennessee AAAD</td>
<td>Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, Washington</td>
<td>Kathy T. Whitaker, Director &lt;br&gt;First TN Dev. District &lt;br&gt;3211 North Roan St. &lt;br&gt;Johnson City, TN 37601-1213 &lt;br&gt;<a href="mailto:kwhitaker@ftaaaad.org">kwhitaker@ftaaaad.org</a> &lt;br&gt;Phone: 423-928-0224 &lt;br&gt;Fax: 423-928-5209</td>
</tr>
<tr>
<td>2</td>
<td>East Tennessee AAAD</td>
<td>Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union</td>
<td>Aaron Bradley, Director &lt;br&gt;East TN Human Resource Agency &lt;br&gt;9111 Cross Park Dr., Suite D100 &lt;br&gt;Knoxville, TN 37923-4517 &lt;br&gt;<a href="mailto:abradley@ethra.org">abradley@ethra.org</a> &lt;br&gt;Phone: 865-691-2551 ext. 4216 &lt;br&gt;Fax: 865-531-7216</td>
</tr>
<tr>
<td>3</td>
<td>Southeast Tennessee AAAD</td>
<td>Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Polk, Rhea, Sequatchie</td>
<td>Steve Witt, Director &lt;br&gt;Southeast TN Dev. District &lt;br&gt;1000 Riverfront Parkway &lt;br&gt;Chattanooga, TN 37402 &lt;br&gt;<a href="mailto:stevew@sedev.org">stevew@sedev.org</a> &lt;br&gt;Phone: 423-266-5781 &lt;br&gt;Fax: 423-424-4225</td>
</tr>
<tr>
<td></td>
<td><strong>Upper Cumberland AAAD</strong></td>
<td></td>
<td><strong>Greater Nashville AAAD</strong></td>
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<tr>
<td>4</td>
<td><strong>Counties Include:</strong> Cannon, Clay, Cumberland, Dekalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren, White</td>
<td></td>
<td><strong>Counties Include:</strong> Cheatham, Davidson, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, Wilson</td>
</tr>
<tr>
<td></td>
<td>Patty Ray, Director</td>
<td></td>
<td>Cathy White, Directory</td>
</tr>
<tr>
<td></td>
<td>Upper Cumberland Dev. District</td>
<td></td>
<td>Greater Nashville Regional Council</td>
</tr>
<tr>
<td></td>
<td>1225 South Willow Avenue</td>
<td></td>
<td>501 Union Street, 6th Floor</td>
</tr>
<tr>
<td></td>
<td>Cookeville, TN 38506-4194</td>
<td></td>
<td>Nashville, TN 37219-1705</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:pray@ucdd.org">pray@ucdd.org</a></td>
<td></td>
<td><a href="mailto:cwhite@gnrc.org">cwhite@gnrc.org</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 931-432-4111</td>
<td></td>
<td>Phone: 615-862-8828</td>
</tr>
<tr>
<td></td>
<td>Fax: 931-432-6010</td>
<td></td>
<td>Fax: 615-862-8840</td>
</tr>
<tr>
<td></td>
<td>Information &amp; Assistance</td>
<td></td>
<td>Information &amp; Assistance</td>
</tr>
<tr>
<td></td>
<td>Phone: 931-432-6170</td>
<td></td>
<td>Phone: 615-255-1010</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="http://www.ucdd.org">www.ucdd.org</a></td>
<td></td>
<td>Website: <a href="http://www.gnrcaaad.org">www.gnrcaaad.org</a></td>
</tr>
<tr>
<td>8</td>
<td><strong>Southwest AAAD</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Counties Include: Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, Madison</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Wanda C. Simmons, Director  
Southwest TN Dev. District  
27 Conrad Dr., Suite 150  
Jackson, TN 38305-2850  
wsimmons@swtdd.org  
Phone: 731-668-7112  
Fax: 731-668-6438 |

<table>
<thead>
<tr>
<th>9</th>
<th><strong>Aging Commission of the Mid-South AAAD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serving the City of Memphis, and Shelby, Fayette, Lauderdale, and Tipton Counties</td>
<td></td>
</tr>
</tbody>
</table>
| Dora Ivey, Director  
Aging Commission of the Mid-South  
2670 Union Avenue Extended, Suite 1000  
Memphis, TN 38112-4428  
divey@agingcommission.org  
Phone: 901-324-6333  
Fax: 901-327-7755 |

2. **UHCCP Members New to CHOICES**

Providers can refer UHCCP members for the CHOICES Program screening and intake by calling the CHOICES Case Management Assistant (CMA) unit at 800-690-1606.

You will need to provide the unit with the member’s name and contact telephone number. The CMA will then call the member to screen them for intake into the CHOICES Program. If the member does not meet eligibility for intake into the CHOICES Program during the screening, the member is informed of his/her right to appeal in compliance with TennCare Rule 1200-13-13-.11.

If the member passes the screening for eligibility into the CHOICES Program, the CMA makes a referral to the appropriate care coordinator for completion of a comprehensive functional assessment, plan of care development, risk assessment completion, risk agreement development, and completion of all required paperwork. The care coordinator will then submit the request to the Bureau of TennCare and Department of Human Services for enrollment into the CHOICES program.

3. **CHOICES Member Groups**

The CHOICES Program consists of three (3) Groups, each with distinct eligibility/enrollment requirements and benefits. CHOICES members qualify for only one of the three groups.
3.1 Group 1
Medicaid members of all ages who receive Medicaid-reimbursed care in a nursing facility

3.2 Group 2
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who meet the nursing facility level of care, who qualify for TennCare either as SSI recipients or as members of the CHOICES 217-Like HCBS Group, and who need and are receiving CHOICES HCBS as an alternative to nursing facility care. The CHOICES 217-Like HCBS Group includes persons who could have been eligible under 42 CFR 435.217 had the state continued its 1915(c) HCBS waiver for elders and/or persons with physical disabilities. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

3.3 Interim Group 3 (open for new enrollment only between July 1, 2012 through June 30, 2015)
Persons age 65 and older and adults age 21 and older with physical disabilities who qualify for TennCare as SSI eligible or as members of MOE Demonstration Group and who meet the NF LOC criteria in place as of June 30, 2012. There is no enrollment target on Interim Group 3.

3.4 Group 3
Persons age sixty-five (65) and older and adults age twenty-one (21) and older with physical disabilities who qualify for TennCare as SSI recipients, who do not meet the nursing facility level of care, but who, in the absence of CHOICES HCBS, are “at-risk” for nursing facility care, as defined by the State. TENNCARE has the discretion to apply an enrollment target to this group, as described in TennCare rules and regulations.

C. CHOICES Benefits

1. CHOICES Services
CHOICES members receive the same benefits as all other UHCCP members. For a completed listing of TennCare benefits, see Chapter V Benefits in this Manual. Additionally, the following long term services and supports are available to CHOICES members when the services have been determined medically necessary by UHCCP.

<table>
<thead>
<tr>
<th>Service and Benefit Limit</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-Based Residential Alternatives</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Personal Care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Attendant Care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home-Delivered Meals (up to 1 meal per day)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
2. CHOICES Consumer Direction

2.1. Consumer-Directed Worker
An individual who has been hired by a CHOICES member participating in consumer direction of HCBS, or his/her representative to provide one or more eligible HCBS to the member. A consumer-directed worker cannot include an employee of an agency that is being paid by an MCO to provide HCBS to the member.

2.2. Consumer Direction of HCBS
The opportunity for a CHOICES member assessed to need specified types of HCBS including attendant care, personal care, in-home respite, companion care and/or any other service specified in TennCare rules and regulations as available for consumer direction to elect to direct and manage (or to have a representative direct and manage) certain aspects of the provision of such services—primarily, the hiring, firing, and day-to-day supervision of consumer directed workers delivering the needed service(s).

2.3. Fiscal Employer Agent (FEA)
An entity contracting with the state and/or an MCO that helps CHOICES members participating in consumer direction of HCBS. The FEA provides both financial administrative services and supports brokerage functions for CHOICES members participating in consumer direction of HCBS.

2.4 Self Direction of Healthcare Tasks
Allows members who elect to employ workers for specified services to also direct and supervise workers in the performance of certain healthcare tasks.

3. CHOICES Cost Neutrality Cap
The cost of providing care to a member in CHOICES Group 2, including HCBS, home health, and private duty nursing, shall not exceed the cost of providing nursing facility services to the member, as determined in accordance with TennCare policy. The level of services actually provided will be based on the member’s needs, as well as the availability of family and other caregivers to meet those needs. The Cost Neutrality Cap reflects the absolute maximum level of service that can be provided in the community to persons with extraordinary levels of need and relatively few natural supports.

### Service and Benefit Limit

<table>
<thead>
<tr>
<th>Service</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Emergency Response Systems (PERS)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Adult Day Care (up to 2080 hours per calendar year)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>In-Home Respite Care (up to 216 hours per calendar year)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>In-Patient Respite Care (up to 9 days per calendar year)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assistive Technology (up to $900 per calendar year)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Minor Home Modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pest Control (up to 9 units per calendar year)</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

The Bureau of TennCare is solely responsible for the addition or deletion of any service or supply.
In no circumstances may the member exceed the cost neutrality cap for care and remain in Group 2. If the member’s needs cannot be safely met without exceeding the cost neutrality cap, the care coordinator will educate the member on transition to Group 1 for nursing home placement.

4. Expenditure Cap

For CHOICES members in Group 3, the annual limit on expenditures for HCBS, excluding home modifications, home health, and private duty nursing services is $15,000.

5. Two Models Available for Community Living Supports

Community Living Supports (CLS) is a community-based residential alternative (CBRA) service for adults 65 and older and adults 21 and older with a physical disability, who are enrolled in CHOICES.

Two models are available: CLS and CLS Family Model. Following is an explanation of each.

**CLS model:** Up to four individuals living in a home that supports each resident’s independence and integration into the community.

- **CLS 1- member benefit limit**
  This level of reimbursement is for CLS services to CHOICES members who are primarily independent or who have family members and other (i.e. non—CHOICES) paid or unpaid supports, but need limited intermittent CKS supports to live safely in a community housing situation—generally less than 21 hours per week—and do not need overnight staff or direct support staff to live on-site for supervision purposes. A primary staff member other support staff must be on-call on a twenty-four (24) hour per day basis when assistance is needed.

- **CLS 2 -**
  This level of reimbursement is for CLS services to CHOICES members who require minimal to moderate support on an ongoing basis, but can be left alone for several hours at a time and do not need overnight staff or direct support staff to live on-site for supervision purposes. A primary staff member or other support staff must be on-call on a twenty-four (24) hour per day basis when assistance is needed.

- **CLS 3 -**
  For members who require support and supervision 24 hours per day. The number of hours the staff is required to care for the member is defined in the person-centered plan of care.

**CLS Family Model:** For up to three individuals living in a home owned or leased by trained family caregivers who are not family members and who live onsite and support each resident’s independence and integration into the community.

- **CLS-FM1 -**
  For independent members who need intermittent CLS to live safely in the community and typically do not require assistance through the night. The number of hours the staff is required to care for the member is defined in the person-centered plan of care. A CLS Family staff member must be on-call 24 hours a day if the caregiver is not on site for part of the day.

- **CLS-FM2 -**
  For members who require minimal to moderate ongoing support, can be left alone for several hours at a time and do not need overnight staff or constant supervision. The number of hours the staff is required to care for the member is defined in the person-centered plan of care. A CLS staff member must be on-call 24 hours a day to assist, if needed.
• CLS-FM3 -
  For members who require support and supervision 24 hours per day. The number of hours the staff is required to care for the member is defined in the person centered-plan of care.

Both models help ensure that member choices and rights are fully supported by the individual’s specific needs and a person-centered plan of care. Members are responsible for room and board and other community living expenses, similar to other CBRAs.

If you would like more information about this cost-effective alternative, please contact your Provider Advocate.

D. CHOICES Assessment

Members who are referred to CHOICES and meet the CHOICES level of care guidelines will receive a face to face assessment in their place of residence from a designated care coordinator which will include a Needs Assessment as well as a Risk Assessment. The Needs Assessment will include the evaluation of existing HCBS services with recommended changes if necessary. A Plan of Care (POC) is initiated based on the Needs Assessment. The assigned care coordinator will work with the member on an ongoing basis to assure that their needs can be met safely and effectively in the least restrictive environment and in accordance with TennCare established benefit limits.

1. CHOICES Level of Care Assessment

For Group 2 and 3 members:

• State determines initial Level of Care (LOC) for CHOICES HCBS, based on the Pre-Admission Evaluation (PAE) submitted by AAAD or the MCO, as applicable.

• LOC must be reassessed by MCO at least annually

For Group 1 members:

• State determines LOC for Nursing Facility (NF) services, based on the PAE submitted by the NF, AAAD or MCO, as applicable.

• NF services must be authorized by the MCO in accordance with LOC established by TennCare.

• Any changes in LOC are submitted to and determined by TennCare.

• LOC must be reassessed at least annually.

2. CHOICES Needs Assessment and Reassessment Process

Each member has an assigned care coordinator who will utilize a comprehensive needs assessment tool to evaluate the long term services and supports needs of the member. Member assessments will be performed by a Registered Nurse (RN), care coordinator or social worker care coordinator within the specified contractual guidelines.

A reassessment of individualized service needs will require an updated Plan of Care. Plan of Care updates will occur minimally one time every quarter for members in the community dwelling receiving HCBS (Groups 2 and 3) and annually for nursing facility residents, (Group 1).
3. CHOICES Care Planning Process

An individualized Plan of Care (POC) is established for each CHOICES member that specifically includes the amount, frequency, duration, and scope of each service needed to support the member in the least restrictive level of care possible. When developing the Plan of Care, the care coordinator considers needs identified during the face to face visit and comprehensive needs assessment, the care plan to address those needs, the facilitation of the plans, and advocacy for the member.

3.1 CHOICES Group 1

For members in CHOICES Group 1, the member’s care coordinator/care coordination team may:

- Rely on the plan of care developed by the nursing facility for service delivery instead of developing a plan of care for the member
- Based on member’s needs, supplement the plan of care as necessary with the development and implementation of targeted strategies to improve health, increase and/or maintain functional abilities to improve quality of life.

Care coordinators will participate in the nursing facility’s care planning process and advocate for the member.

3.2 CHOICES Groups 2 and 3

The care coordinator will coordinate and facilitate a care planning team that includes the member and the member’s care coordinator. The care coordinator will include or seek input from other individuals such as the member’s representative or other persons authorized by the member to assist with needs assessment and care planning activities.

Care coordinators will consult with the member’s Primary Care Provider (PCP), specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed when developing the plan of care. The care coordinator will verify that the decisions made by the care planning team are documented in a written, comprehensive plan of care.

The care coordinator/care coordination team will ensure that the member reviews, signs, and dates the plan of care as well as any updates.

E. CHOICES Care Coordination

Members and/or their representatives play a critical role in the TennCare CHOICES Program and are invited to participate actively in the assessment and care planning process. Care coordinators include members in their health care decisions and encourage members to participate to the extent of their ability and willingness to do so. UHCCP’s focus on self-management requires an assessment and understanding of the member’s needs, values, health beliefs, and cultural influences and how these influences drive behavior and decisions about his or her health care.

The care coordinator works closely with the member and his or her family or representative to develop a care plan, using the results of the health and functional assessment. This process combined with medical record and utilization claims review, helps to develop the members clinical treatment goals.
Our care coordination:

- Integrates primary, acute, behavioral, and long term services and supports into one consumer-driven, seamless system of care.

- Provides members with timely, medically necessary health care services in the least restrictive and most appropriate setting.

- Focuses on preventative, primary, and secondary care that slows illness progression and disability.

- Involves members, caregivers, physicians, and other providers in the care planning process.

- Works in collaboration with providers, caregivers, and others who are involved in the care of the member.

- Each member will be assigned a care coordinator who will assist in planning and coordinating his or her care.

1. Role of the CHOICES Care Coordinator

Care Coordinator responsibilities for all members include:

- Collaborating with nursing facilities to verify monthly census of CHOICES Group 1 members in the facilities

- Coordinating a multidisciplinary team to develop individualized plans of care. The team includes the PCP, other providers as appropriate, the member, and others as determined by the member (caregivers, significant others, etc).

- Conducting health and functional assessments.

- Developing the care plan based upon results of the assessment.

- Coordinating services with other providers such as Behavioral Health and other community services.

- Utilizing compiled data received from member encounters to assure the services being provided meet member needs.

- Facilitating access to services.

- Providing assistance in resolving any concerns about care delivery or providers.

Care coordinators will send copies of the care plans and reassessments to the PCPs upon request. Care Coordinators may make calls to the PCP with specific concerns about the member. For example, if the care coordinator believes the member is non-compliant with his or her medical plan, the care coordinator will call the PCP to discuss these concerns. For PCPs with a higher volume of UHCCP members, we have available even more specific interfaces to facilitate the best outcomes for members. These include case reviews with the Medical Director that would include the PCP and other members of the care team (family, caregiver, other providers).

2. Contacting the CHOICES Care Coordinator

Providers are responsible for notifying the care coordinator as expeditiously as warranted by the member’s circumstances when significant changes in conditions occur, the member is hospitalized, or the provider recommends additional services.
Changes in Condition include, but are not limited to:

**Group 1**

- Pattern of recurring falls
- Incident, injury, or complaint
- Report of abuse or neglect
- Frequent hospitalizations
- Prolonged or significant change in health and/or functional status

**Groups 2 and 3**

- Change of residence or primary caregiver or loss of essential social supports
- Significant change in health and/or functional status
- Loss of mobility
- An event that significantly increases the perceived risk to a member
- Member has been referred to Adult Protective Services (APS) because of abuse, neglect, or exploitation

Providers shall also contact their care coordinator in the event of:

- Skin integrity issues
- Behavioral health issues
- Hospice election
- Member needs outpatient therapies including PT/OT/SP/RT

**3. Contacting the UHCCP Care Management Associate (CMA)**

Providers should contact a UHCCP CMA if any of the following occur:

- Inability to contact member
- Any deviations from a member’s service schedule
- Member unexpectedly leaves his or her place of residence
- Member is admitted to the hospital
- Bed hold and therapeutic leave requests (Nursing Facilities only)
- Death of a member
Providers can reach a UHCCP CMA by calling 877-552-8106.

4. Service Authorizations

UHCCP does not require HCBS to be ordered by a treating physician, but the care coordinator may consult with the treating physician as appropriate regarding the member’s physical health, behavioral health, and long term services and supports needs. The CHOICES member care coordinator will evaluate service needs and develop the member individualized Plan of Care. HCBS levels of care are determined through the needs assessment and the assessment of natural supports.

If you have any questions regarding authorizations, please contact our Care Management Associates (CMA) at 800-690-1606.

F. CHOICES Patient Liability

Patient liability is a monthly amount that persons receiving Medicaid LTSS services (nursing facility or HCBS) are required to contribute toward the cost of their care.

UHCCP will deduct patient liability for Group 2 and Group 3 members, residing in a Community Based Residential Alternative (CBRA). UHCCP will pay the facility net of the applicable patient liability amount.

UHCCP will collect patient liability from CHOICES Group 2 and Group 3 members (as applicable) who receive CHOICES HCBS in his/her own home, including members who are receiving short term nursing facility care, or who receive adult day care services, and from Group 2 members who receive Companion Care.

G. LTSS Provider Responsibility

1. Service Requirements for HCBS providers:

   • HCBS will provide services in accordance with the plan of care including the amount, frequency, duration, and scope of each service in accordance with the member’s service schedule.

   • HCBS providers utilizing Electronic Visit Verification (EVV) will be responsible for monitoring and immediately addressing service gaps, to include back-up staff. Providers using EVV are: personal care, attendant care, in-home respite, and home delivered meals. All other HCBS providers will file claims electronically on a UB04 Form.

   • HCBS providers are prohibited from soliciting members to receive services including:

     – Referring an individual for CHOICES screening and intake with the expectation that should CHOICES enrollment occur, the provider will be selected by the member as the service provider.
• Communicating with existing CHOICES members via telephone, face-to-face, or written communication for the purpose of petitioning the member to change CHOICES providers

• In the event a member is admitted to the hospital, LTSS providers will notify UHCCP via fax forms. Nursing Facilities will utilize the Transfer form. HCBS providers will use the Hospital form.

• HCBS providers must accept and agree to start services for Money Follows the Person (MFP) eligible members with a faxed authorization.

• HCBS providers must comply with critical incident reporting and management requirements, including use of the Critical Incident training videos as part of orientation for new employees. These videos can be found at: http://www.uhcommunityplan.com/health-professionals/tn/provider-education.html.

• The member’s care coordinator/care coordination team shall provide a copy of the member’s completed plan of care, including any updates to the member, the member’s representative, as applicable, and the member’s community-based residential alternative provider, as applicable, and other providers authorized to deliver care to the member. Each provider must sign the plan of care indicating that they understand and agree to provide the services as described prior to the schedule implementation of services and prior to any change in such services. Electronic signatures will be accepted.

• At a minimum, recredentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5).

• Prior to executing a provider agreement with any CHOICES HCBS provider seeking Medicaid reimbursement for CHOICES HCBS, UHCCP shall verify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5).

• UHCCP shall require that all CHOICES HCBS providers maintain compliance with the HCBS Settings Rule.

• New providers – UHCCP will require the completion of the HCBS self-assessment with accompanying policies/procedures and transition plans, if applicable. The credentialing process will not proceed until all elements of the self-assessment have been submitted and approved by UHCCP. Note: no provider is grandfathered in this process, all providers must comply.

• Existing providers – UHCCP’s Provider Advocates will conduct on-site assessments with each HCBS provider and request copies of the documents submitted to satisfy the HCBS self-assessment. If there are any changes since the completion of the documents, the HCBS provider must disclose any changes that may adversely affect the content of the initial submission.

• UHCCP will conduct UHC ON AIR (formerly UPNN) presentations with HCBS providers to train providers on the requirements and address any questions or concerns that providers may have when completing the HCBS self-assessment. Notices will be forwarded to providers once the presentations are scheduled.

### 2. Background Check Requirements

Providers will need to perform background checks on employees which includes criminal background check or, as an alternative, a background check from a licensed private investigation company, verification that the person’s name does not appear on the State abuse registry, verification that the person’s name does not appear on the state and national sexual offender registries and licensure verification. Providers are required to conduct background checks on employees, subcontractors, and agents, prior to rendering services, in accordance with state law and TennCare policy.
Additionally, Providers are required to screen all employees and contractors (“Screened Persons”) against the Federal Exclusions Lists initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal or state health care programs (as defined in Section 1128B(f) of the Social Security Act). Providers should not employ or contract with any individual or entity who is excluded from participation in Medicare, Medicaid, SCHIP, or any Federal or state health care programs or with an entity that employs or contracts with such an individual or entity. Providers should immediately report to your Senior Provider Relations Advocate of any exclusion information discovered. Civil monetary penalties may be imposed against entities who employ or enter into contracts with excluded individuals or entities to provider items or services to TennCare members. The background check MUST BE completed and the results received before the individual can provide services to a CHOICES member. Pursuant to the Equal Employment Opportunity Commission (EEOC) providers must have in place policies and procedures addressing processes for exceptions. Guidance can be located at: http://www.eeoc.gov/laws/guidance/arrest_conviction.cfm.

Nursing facilities will continue to perform background checks as they have in the past, in accordance with Health Facilities survey and CMS survey requirements.

3. Service Authorization Requirements and Processes

Nursing facility services will be authorized in accordance with approved PAE, as determined by TennCare. TennCare will continue to evaluate and approve all PASRR submissions. Nursing facilities must notify UHCCP of bed holds by contacting the care coordinator or speaking with a CMA at 800-690-1606. Nursing facilities receiving a member transferred from another facility must complete a transfer form and fax to TennCare and UHCCP. HCBS providers will receive a faxed authorization confirmation summary and have the ability to review authorizations via the Electronic Visit Verification (EVV) System.

Nursing facility providers submitting an authorization request to UnitedHealthcare for ventilator weaning, chronic ventilator care, and/or tracheal suctioning must indicate whether the ERC service is/is not in addition to standard nursing facility or skilled nursing facility services.

If UHCCP submits a level of care application to TennCare for a member in a nursing facility, the care coordinator shall, as expeditiously as possible and within no more than two (2) business days, notify the nursing facility that the level of care application has been submitted, and provide a copy of the application to the nursing facility.

4. Eventa Assisting with Oversight of Enhanced Respiratory Care

As of July 1, 2015 we are working with Eventa, LLC to provide quality oversight and monitoring for enhanced respiratory care (ERC). ERC refers to enhanced levels of care in a nursing facility, including chronic ventilator care, ventilator liberation or weaning and tracheal suctioning.

Eventa will conduct on-site reviews on our behalf with respiratory care practitioners to monitor the quality of care provided to each member receiving services at a facility. They will also provide training at the nine facilities licensed by Tennessee Department of Health, Health Care Facilities, which are:

- Bordeaux Long Term Care
- Dove Health and Rehab of Collierville
- Greystone Healthcare Center
- The Health Care Center at Standifer Place
- Signature Healthcare at Saint Francis
- Spring Gate Rehabilitation and Healthcare Center
- Trevecca Health Care Center
- The Wexford House
- WyndRidge Health and Rehabilitation
H. CHOICES Provider Critical Incident Reporting

UHCCP requires participating CHOICES providers to report all Critical Incidents that occur in a home and community-based long term services and supports delivery setting, including assisted-living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member’s home, if the incident is related to the provision of HCBS. Critical incidents include but are not limited to:

- Unexpected death of a CHOICES member
- Suspected physical or mental abuse of a CHOICES member
- Theft against a CHOICES member.
- Severe injury sustained by a CHOICES member
- Financial exploitation of a CHOICES member
- Medication error involving a CHOICES member
- Sexual abuse and/or suspected sexual abuse of a CHOICES member
- Abuse and neglect and/or suspected abuse and neglect of a CHOICES member

Providers must contact a regional Clinical Quality Analyst (CQA) for UHCCP with a verbal report of the incident within 24 hours (calendar hours, not working hours) of their knowledge of the incident. The verbal report, at a minimum, must include member name, date of birth, date and time of incident, a brief description of the incident, member’s current condition, and actions taken to mitigate risk to the member. If the incident involves abuse, neglect, or financial exploitation of a CHOICES member, providers also must report the incident to Adult Protective Services. A written report (Critical Incident Reporting Form) must be submitted to UHCCP, via fax or secure email, no later than 48 hours (calendar hours, not working hours) following the discovery of the incident. Providers must cooperate fully in the investigation of CHOICES critical incidents, including submitting all requested documentation. If the incident involves an employee of an HCBS provider, the provider must also submit a written report of the incident including actions taken, within twenty (20) calendar days of the incident. CQA contact information and secure fax number is located on the Critical Incident Reporting Form. To protect the safety of the member, actions that must be taken immediately include, but are not limited to the following:

- Notify APS immediately in all incidents involving abuse, neglect, or financial exploitation
- Take steps to prevent further harm to member and respond to any emergency needs of member
- Remove accused worker from providing services to the member and all TennCare Choices members.
- Immediately remove accused worker from servicing all TennCare CHOICES members until the investigation is complete. The investigation, based on the severity of the incident, may take up to 30 calendar days.
- Order immediate drug screen or appropriate testing if allegation includes theft of drugs or use of substances including alcohol while on the job.
- Interview involved employee(s) as soon as possible following the incident. Have this/these employee(s) submit a written account of the events. Fax these written accounts to UHCCP along with documentation to support completion of pre-employment screenings including background checks, drug screening, and a statement that the employee did not begin to perform services for UHCCP CHOICES members until all required pre-employment screenings were completed and verified.
Based upon the severity of the incident, any identified trend, or failure on the part of the provider to cooperate with any part of the investigation, the provider may be required to submit a written plan of correction to address/correct any problem or deficiency surrounding the critical incident. Failure to submit written plan of corrections within the time frame indicated on the request and subsequent problems or deficiencies surrounding critical incident reporting, investigations or cooperation of the provider can and will result in further actions up to and including closed panels and contract termination. A copy of the CHOICES Critical Incident Reporting Form is listed in the Forms Appendix of this Manual. This form can also be found at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-CriticalIncidentReportingForm.pdf.

UHCCP has recorded two on-demand training videos that give an overview of critical incident reporting and investigation. The first video is more in depth and appropriate for office staff and management. The second video may be used by HCBS providers for new employee orientation or re-education for employees who interact directly with CHOICES HCBS members. The videos are located at https://vts.inxpo.com/Launch/Event.htm?ShowKey=17326&DisplayItem=E122625 and https://vts.inxpo.com/Launch/Event.htm?ShowKey=17326&DisplayItem=E122623. HCBS Providers are required to view the videos at least annually and to incorporate the appropriate video into orientation for all new employees.

I. Home Based Community Services

HCBS providers should utilize appropriate documentation practices to ensure quality of care. Regulatory standards may be assessed. UHCCP utilizes the Provider Requirements Standards Assessment and Documentation Review form to assess quality of care practices. The Provider Requirements Standards Assessment and Documentation Review form is located in the Forms Appendix of this Manual and on the UHCCP website at http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-ProviderReqAssessmentForm.pdf.

Effective July 1, 2015, the following requirements apply for home and community-based services (HCBS):

HCBS providers:

- **Providers must sign the Plan of Care**
  The member’s care coordinator/care coordination team must provide a copy of the member’s completed plan of care, including any updates, to the member, the member’s representative, as applicable, and the member’s community-based residential alternative provider and other providers authorized to deliver care to the member.

  Each provider must sign the plan of care indicating they understand and agree to provide the services described prior to the schedule implementation of services and any change in those services. Electronic signatures cannot be accepted.

- **HCBS Settings Rules**
  At a minimum, recredentialing of HCBS providers will include verification of continued licensure and/or certification; compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5).

  For providers not yet in our network: Prior to executing a provider agreement with any CHOICES HCBS provider seeking reimbursement for CHOICES HCBS, we will verify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R. 441.301(c)(4)-(5).
We will require that all CHOICES HCBS providers maintain compliance with the HCBS Settings Rule and complete the HCBS self-assessment with accompanying policies/procedures and transition plans. The credentialing process cannot be completed until all elements of the self-assessment are submitted and approved by UnitedHealthcare Community Plan. Note: if the provider has previously submitted a completed HCBS self-assessment, UnitedHealthcare Community Plan will request a copy of the documents; the provider is not required to complete the full HCBS self assessment again. All providers must comply and no providers can be grandfathered in this process.

For network providers: Provider Advocates will conduct on-site assessments with each HCBS provider and request copies of the documents submitted to satisfy the HCBS self-assessment. If there are any changes since the completion of the documents, the HCBS provider must disclose any changes that may adversely affect the content of the initial submission.

We will conduct UnitedHealthcare On Air presentations with HCBS providers to train them on the requirements and answer questions they have when completing the HCBS self-assessment. (UnitedHealthcare On Air is a web-based tool for provider communication and training). Training schedules to be announced.

J. CHOICES Claims Filing Tips

1. Billing for Nursing Facility Room and Board Services

Billing for nursing facility room and board services will be received electronically on a UB04 claim form. Claims may be received through your EDI vendor which will be communicated through our Clearing House ENS by Ingenix.

The provider may also use Office Ally to submit electronic claims or submit a manual paper claim. The provider may also use Office Ally to submit electronic claims. Office Ally is a web-based claims submission service that is free to the provider. For more information about Office Ally, please visit www.officeally.com.

Revenue Codes for Room and Board:

- 191 ICF or level 1
- 192 Skilled or Level 2
- 192 plus CPT Code 94004 – Chronic Vent
- 192 plus CPT Code 94004 with Modifier 22 – Vent Weaning
- 192 plus CPT Code 94004 with Modifier 52 – Trach Suction
- 183 Therapeutic Leave – Overnight home visits for ICF only
- 185 Nursing home – hospital bed hold for ICF only
- 189 Other – Non-covered day – ICF, SNF and ICF-MR
- 224 Day of discharge if member expires after 12 p.m.
When sending the Provider Identification Number (PIN) on your UB04 claim to UHCCP via the Office Ally form, please enter the PIN in FL57 and the Payer ID (95378) in FL51. If you are submitting claims using another software vendor, but using Office Ally as the clearinghouse to send your claim, please map the PIN to 2010AA REF segment with a qualifier F2. The payer ID will then go in to FL50 with the UHCCP name. For nursing facility providers, please enter the physicians date with the occurrence code 54 in FL 31.

Please be sure to enter your tax identification number in FL5 and use the correct bill type for the service you are performing.

2. Bill Types

Nursing Home

- 66x – Level 1 Nursing Facility
- 21x – Level 2 Nursing Facility

HCBS

- 89x – HCBS services

X=

- 1 – Admit
- 2 – Initial or first-time billing
- 3 – Intermediate ongoing/continuing
- 4 – Final billing (discharge or death)
- 7 – Corrected Claim

3. HCBS Claims Submissions

3.1 EVV

Providers will submit claims for these services through EVV:

- Attendant Care
- Home Delivered Meals
- In-home Respite
- Personal Care

Usage and Dedicated Resources

UnitedHealthcare monitors specific CHOICES services through an Electronic Visit Verification (EVV) system. Those services include: in-home respite, personal care, attendant care, and home delivered meals.

Effective 10/1/2015, the use of a GPS device in each UnitedHealthcare member’s home receiving these services was implemented, and Healthstar was contracted as the vendor of choice.
UnitedHealthcare’s expectation is that all contracted providers use the EVV system for the applicable services. Contracted providers must also have at least two staff persons that are fully trained on the EVV system and can train caregivers on utilizing the device in member homes. An additional expectation is that at least one staff person with the contracted provider is dedicated to monitor caregiver activity to ensure that caregivers are in the member’s home providing services at the scheduled time that was agreed upon when the referral was accepted.

It is imperative that providers comply with these standards to ensure that members are receiving services timely. Failure to comply will result in disciplinary action, up to and including termination from the UnitedHealthcare network.

3.2 Office Ally or Electronic

Providers will submit claims for these services electronically or through Office Ally:

- Adult Care Home
- Assistive Technology
- PERS – Installation
- Adult Day Care
- In-patient Respite
- PERS – Monthly
- Assisted Living Facility Daily
- Minor Home Modifications
- SNF Short Stay
- Assisted Living Facility Monthly
- Pest Control
### 3.3 Billing Codes

<table>
<thead>
<tr>
<th>Provider Service</th>
<th>HCPCS</th>
<th>Revenue Code</th>
<th>BENEFIT LIMITS</th>
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</thead>
<tbody>
<tr>
<td>Attendant Care</td>
<td>S5125</td>
<td>0570</td>
<td>Up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks</td>
</tr>
<tr>
<td>Personal Care</td>
<td>T1019</td>
<td>0570</td>
<td>2 visits per day; Visits may be no longer than 4 hours</td>
</tr>
<tr>
<td>In-home Respite</td>
<td>S5150</td>
<td>0660</td>
<td>216 hours per calendar year</td>
</tr>
<tr>
<td>Home Delivered Meals Fresh</td>
<td>S5170</td>
<td>0590 (Mod U1)</td>
<td>1 meal per day</td>
</tr>
<tr>
<td>Home Delivered Meals Shipped</td>
<td>S5170</td>
<td>0590</td>
<td>Benefit Limit 1 meal per day</td>
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<tr>
<td>Companion Care 5 days</td>
<td>S5136</td>
<td>0570 (Mod U1)</td>
<td>TBD</td>
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<tr>
<td>Companion Care 7 days</td>
<td>S5136</td>
<td>0570 (Mod U2)</td>
<td>TBD</td>
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<tr>
<td>Companion Care Back up</td>
<td>S5136</td>
<td>0570</td>
<td>TBD</td>
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<td>Adult Day Care</td>
<td>S5100</td>
<td>0570</td>
<td>2080 hours per calendar year</td>
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<td>Assisted Living Monthly</td>
<td>T2030</td>
<td>3109</td>
<td>12 months per year</td>
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<tr>
<td>Assisting Living Daily</td>
<td>T2031</td>
<td>3109</td>
<td>1 Unit per Day</td>
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<td>Assistive Technology</td>
<td>T2029</td>
<td>0590 (Mod U4)</td>
<td>$900 per calendar year</td>
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<td>In-patient Respite</td>
<td>S5151</td>
<td>0660</td>
<td>9 days per calendar year</td>
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<td>Minor Home Modifications</td>
<td>S5 165</td>
<td>0590</td>
<td>$6,000/project; $10,000/calendar year; and $20,000/lifetime</td>
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<td>PERS Installation</td>
<td>S5160</td>
<td>0590</td>
<td>1 unit</td>
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<tr>
<td>PERS Monthly Monitoring</td>
<td>S5161</td>
<td>0590</td>
<td>12 months per year</td>
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<tr>
<td>Pest Control</td>
<td>S5121</td>
<td>0590 (Mod U1)</td>
<td>9 units per calendar year</td>
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<td>Adult Home Level 2 TBI</td>
<td>T2033</td>
<td>3109 (Mod U1)</td>
<td>TBD</td>
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<tr>
<td>Adult Home Level 2 Vent</td>
<td>T2033</td>
<td>3109 (Mod U2)</td>
<td>TBD</td>
</tr>
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</table>
3.4 Billing of Claims for Transitioning Members

• If a transitioning member is enrolled in CHOICES Group 1, any CHOICES HCBS that must be completed prior to a member’s transition from a nursing facility to the community in order to ensure the member’s health and safety upon transition (i.e. minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member is enrolled in Group 1, but shall be billed as a Group 2 services once the member is enrolled into Group 2, with the date of service as the effective date of enrollment in CHOICES Group 2.

• If a transitioning member is enrolled in CHOICES Group 2 or 3 but is receiving short-term nursing facility care, any CHOICES HCBS that must be completed prior to a member’s transition from a nursing facility to the community in order to ensure the member’s health and safety upon transition (i.e. minor home modifications, adaptive equipment, or PERS installation) shall be completed while the member resides in the facility and billed as a Group 2 or Group 3 service, as applicable. However, a member shall not be transitioned from CHOICES Group 1 into Group 2 or 3 for receipt of short-term nursing facility services in order to provide these services. Short-term nursing facility care is available only to a CHOICES 2 or CHOICES 3 participant who was receiving home and community based services upon admission to the short-term nursing facility stay.

4. Timely Filing Criteria

UHCCP TennCare timely filing guidelines are 120 calendar days from date of service. If UHCCP receives a claim and it requires additional information in order to be processed and paid, the claim will be denied with a request for the additional information. In order to avoid denial for timely filing, you must re-file the claim within 60 days of the UHCCP denial of the claim. Disputes for claims reimbursement or denials must be submitted with written documentation within 365 calendar days from the date the claim processed. Should a member have primary coverage, the 120 day period begins on the date of primary EOB. If UHCCP is the secondary insurance carrier, then claims must be submitted and received within 120 days from the date on the primary insurance carrier’s EOB and/or EOMB.

For additional information regarding Timely Filing Criteria, please see Chapter VI, Section A-6.

5. NPI Filing Requirements

A National Provider Identifier (NPI) is required for all TennCare medical providers including CHOICES. All provider identifiers must be valid NPI numbers.

This includes billing, servicing, rendering, attending, operating, referring, and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in the optional fields, it must follow the NPI requirements.

If you are an a-typical provider (i.e., a provider of non-medical services), a Provider Identification Number (PIN) will be assigned to you. The PIN may be entered in FL57 of the UB04.
6. Provider Claim Inquiries and Formal Claim Disputes

Please refer to Chapter VI, Section C for information outlining the process for Provider Claim Inquiries and Formal Claim Disputes.

7. Retro-Eligible Process for Filing Claims

If you are submitting a claim for a CHOICES member whose benefits were retroactively assigned after your practice has delivered services, prepare and complete an accurate CMS-1500 (formerly HCFA) or UB-04 claim form. You may submit a paper or electronic claim.

If retro eligible authorization review is needed, the Medical Review Unit will request documentation from the provider via fax. UHCCP will not deny payment due to lack of prior authorization for medically necessary covered services rendered prior to eligibility being established.

If a member is retroactively enrolled, a claim must be submitted within 120 days of the date TennCare informs UHCCP of the member’s eligibility.

8. Corrected Claims

When altering claims for resubmission, please use a "7" frequency in the appropriate bill type to denote a corrected claim. Also, please indicate the claim number you are correcting in FL 64.
**K. Electronic Visit Verification Registration**

Providers wanting to register for EVV, should fill out an EVV Registration Form. This form is available in the Forms Appendix of this Manual and on the UHCCP website at [http://www.uhccommunityplan.com/assets/TN-EVVRegistrationForm.pdf](http://www.uhccommunityplan.com/assets/TN-EVVRegistrationForm.pdf). Once completed, providers should submit this form to HealthStar. For questions regarding the completion of this form, providers should call HealthStar Customer Service at 877-526-0516.

On October 1, 2015, our new Electronic Visit Verification (EVV) system will launch, operated on our behalf by HealthStar, a Tennessee-based company that will service the CHOICES provider network from its office in Franklin.

The system was developed with our providers who deliver services to CHOICES members in mind.

Our EVV will provide many features that you have been requesting during the past few years. They include:

- Flexible schedule deviation
- Electronic schedule requests
- Managed care organization communication within the EVV system
- Auto assignment of a worker at a visit
- An actionable dashboard

We are working with a subset of care providers to conduct user acceptance testing on the new system to help us identify and correct any system issues prior to full implementation.

The new EVV process was created as a result of new requirements:

- The ability to log the arrival and departure of an individual provider staff person or worker, through the use of a static GPS device provided to the member for the sole purpose of this program.
- The ability to capture the arrival and departure of an individual provider staff person or worker through the member's phone number in the event there is a malfunction with the GPS device;
- The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home).
- The ability to verify the identity of the individual provider staff person or worker providing the service to the member.

We will share more information about the EVV system and announce training session before the October 1 start date. If you have any questions, please contact your Provider Advocate or consult the Healthstar provider manual located at [http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Provider-Information/TN_HealthStar_Provider_Training_Manual.pdf](http://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/TN-Provider-Information/TN_HealthStar_Provider_Training_Manual.pdf).
L. Discharge Guidelines

1. Nursing Home/ Long Term Services and Supports Facilities

Transfer and Discharge Guidelines

Long Term Services and Supports Facilities participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges, and/or readmissions.

1.1 Transfer and Discharge Rights

A Long Term Services and Supports Facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

- Resident's needs can no longer be met in the facility and it is necessary to resident's well being
- Through the Nursing Facility Diversion Plan, eligible members will be transitioned from a Nursing Facility setting to the Community when residents health and well being has drastically improved and the level of services provided by the facility is no longer needed
- The safety of the resident is endangered at a facility
- The health of the resident is endangered at a facility
- The resident has failed to meet his or her financial responsibilities for the facility or under (Title XIX or Title XVIII on the resident’s behalf) have not paid for stay at the facility
- Facility is no longer operational

The order must come directly from a Physician. In a case in which a resident becomes eligible for assistance under Title XIX after admission to the facility, only the charges which may be applicable under Title XIX shall be covered.

A care coordinator in an ongoing process of coordination will assess a member’s physical, behavioral, functional, and psychosocial needs. When the member’s health or medical needs change and/or upon transfer or discharge of the member, the care coordinator must be notified. Please refer to “Contacting the UHCCP Care Coordinator” in section E of this chapter for more information.

When a patient is transferred, a summary of treatment given at the facility, condition of the patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency, this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transport of the patient.
When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the care coordinator and to the Long Term Services and Supports Facility that will continue the care of the patient.

1.2 Pre-transfer and Pre-discharge Notice

Before effecting a transfer or discharge of a resident, a Long Term Services and Supports Facility must:

- Notify the member’s care coordinator
- Notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore
- Record the reasons in the resident’s clinical record (including any documentation required) and include in the notice the items described below.
- Notify the Department of Health Division of Health Care Facilities and the long term care Ombudsman
- Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing

1.3 Timing of Notice

The notice must be provided at least thirty (30) calendar days in advance of the resident’s transfer or discharge except:

- If the resident’s safety and health is in danger
- Resident’s health or needs have improved and through the Nursing Facility Diversion Plan the resident will transition from the Nursing Facility to the Community
- Residents medical needs require an immediate transfer
- Resident has not resided in the facility for more than 30 calendar days

With the exceptions listed above, notice must be given in as much advance as possible before the date of transfer or discharge.

1.4 Items to include in Pre-transfer and Pre-discharge notice:

- Notice of the resident’s right to appeal the transfer or discharge if transfers or discharges were effected on or after October 1, 1990.
- The name, mailing address, and telephone number of the long-term care ombudsman
- In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals
- In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act.
A Long Term Services and Supports Facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer of discharge from the facility.

1.5 Notice of Bed-hold Policy and Readmission

Before a resident of a Long Term Services and Supports Facility is transferred for hospitalization or therapeutic leave, a Long Term Services and Supports Facility must provide written information to the care coordinator, resident, and a family member or legal representative concerning:

- The remaining amount of time eligible (if any) for member to resume residency in that facility under the State plan Title XIX
- The policies of the facility consistent with Notice upon transfer, regarding such a period

1.6 Notice upon Transfer

- When a resident is transferred to a hospital or for therapeutic leave, the Long Term Services and Supports Facility must provide written notice regarding the remaining amount of time (if any) for member to resume residency in that facility under the State plan Title XIX
- This notice must be submitted to the care coordinator, resident, and a family member or legal representative of the member

2. HCBS

2.1 Reasons for Discharge from HCBS

- Plan of Care Change
  - Member no longer needs service as determined by plan of care
- Member or family make a request for services to stop
- Member is transitioned to Group 1
- Loss of eligibility in the CHOICES Program
  - During monthly eligibility determination, provider determines if member is losing eligibility via Tennessee Anytime or UHCCP online or call center
  - Please note that authorizations are not a guarantee of payment. Member must be eligible for services within the month serviced.
- Member not receiving ongoing monthly HCBS service

In these instances, UHCCP will:
- Send a faxed notification of stopping services to the HCBS provider
- Send a letter notifying the member of service changes if required by the Grier Consent Decree.
2.2 Provider Initiated Discharge from HCBS

For Provider Initiated HCBS Discharges, the provider should notify UHCCP in writing 30 days prior to discharge. Please email notification to tn_ltc_choices_cma@uhc.com or fax to 888-582-1963.

Please include the reason for discharge, for example:

• Environment not safe for provider to provide services
• Member’s level of service cannot be met by provider
• Member or family request provider to stop services
• Provider going out of business (see termination section of provider agreement)

M. Provider Credentialing/Verification

Participation in the UHCCP LTSS Provider Network requires satisfaction of application network participation and credentialing/verification requirements.

1. HCBS CHOICES Providers

1.1 Participation and Credentialing

To request participation and credentialing for HCBC providers:

• To speak to a CHOICES Provider Relations Advocate, call 800-690-1606 or e-mail us at tn_ltc_networkmail@uhc.com
• CHOICES HCBS application is available at the following link: http://www.uhccommunityplan.com/assets/TN-LTCPProviderApplication.pdf

UHCCP will require the following:

• HCBS Medicaid ID Issued by TennCare
• Completed Application
• Licensed as appropriate for the service being contracted
• On-Site review and assessment performed by a Long Term Services and Supports Provider Relations Advocate
• Procedures governing financial responsibility and documentation of sufficient cash flow for three (3) months; financial statements, and no filing or history of bankruptcy in the last seven years
• Documented methods to monitor and review services and to assure quality of care
• Monthly verification that agency and/or employees has not been excluded from Medicare/Medicaid participation
• Evidence of compliance with all applicable laws and regulations, including Workman's Compensation and
  unemployment insurance and general liability insurance
• For agency and employees, no felonies or listings on abuse and sex offender registries
• Documentation of staff member background checks, qualifications, trainings, and certifications
• Documentation of verifying financial capacity to operate
• Membership of Board of Directors
• Documented service delivery assurances
• Compliance with HIPAA requirements
• Accurate completion of a Disclosure of Ownership and Control Interest Statement and disclosure of ownership
  information at anytime upon request
• Submission of a W-9 Form
• Signed attestation for the accuracy and completion of all required forms
• Submission of a dequate Proof of Liability insurance ($500,000)
• Standards Assessment and Documentation Review

TennCare requires UnitedHealthcare to contract with providers that maintain a valid license at all times. As a result,
United Healthcare has established a dedicated email address that allows providers to submit updated licenses and
certificates of insurance.

Please submit updated documents to tn_ltc_networkmail@uhc.com as soon as the updated documents are received to
ensure compliance with your contract with United Healthcare. If you have any questions, please contact your Provider
Advocate.

1.2 Demographic Changes
It is important to notify us of any demographic changes 30 days prior to the change becoming effective. Some examples
of these changes include location, telephone number, license changes, Tax Identification Number, or panel status changes.
To notify UHCCP of demographic changes please access the CHOICES HCBS Provider Change Form is available at
the following link: http://www.uhccommunityplan.com/assets/TN-LTCProviderChangeForm.pdf.

2. Nursing Home CHOICES Providers
To Request Participation and Credentialing please email UHCCP at tn_ltc_networkmail@uhc.com or contact your regional
Provider Relations Advocate at 800-690-1606. In addition, contact the United Voice Portal as instructed below.
• 877-842-3210 United Voice Portal
• Enter Tax ID
• Select “Option 5”
• Select “credential”
• Select “medical”
• Select “Join the network”
• The prompt will list various information and ask if you have that information. Say “yes”, and you will be connected to a credentialing representative.

If currently credentialed with UHC, to request UHCCP TennCare participation:

• 877-842-3210 United Voice Portal
• Enter Tax ID
• Request to speak with a Network Management representative for Nursing Facility contract
• Provider must submit the signed disclosures and Medicaid Provider Number with signed contract

To check Credentialing Application Status:

• 877-842-3210 United Voice Portal
• Select “HealthCare Professional Services”
• Select “Credentialing”
• Select “Get Status”
• You can also contact a CHOICES Provider Relations Advocate by phone at 800-690-1606 or email UHCCP at tn_ltc_networkmail@uhc.com.

UHCCP will require the following:

• Completed Application
• Licensed as appropriate for the service being contracted
• Proof of accreditation or Medicare certification
• Sit visit required only if there is not Medicare certification or accreditation by an approved entity.
• Meet qualifications at outlined in the credentialing plan under CMS and NCQA
• Monthly verification that agency and/or employees has not been excluded from Medicare/Medicaid participation
• Evidence of compliance with all applicable laws and regulations, including Workman’s Compensation and unemployment insurance and general liability insurance
• For agency and employees, no felonies or listings on abuse and sex offender registries
• Documentation of verifying financial capacity to operate
• Documented service delivery assurances
• Compliance with HIPAA requirements
• Accurate completion of a Disclosure of Ownership and Control Interest Statement and disclosure of ownership information at anytime upon request

• Submission of a Substitute W-9 Form

• Signed attestation for the accuracy and completion of all required forms

• Assignment of a valid Medicaid number

• Site Visits to ensure adequate record keeping

• Standards Assessment and Documentation Review

N. TennCare Regulatory Requirements Appendix

Additional provider requirements are set forth in the TennCare Regulatory Requirements Appendix (formerly known as the TennCare Addendum) located in chapter XXIV of this manual. Contracting providers agree to comply with the language requirements set forth in the Addendum in addition to the provisions of the Tennessee Program Network Provider Agreement. As noted in the Modification section of your provider agreement, required language can be updated by inclusion in the provider manual. If any requirement in the TennCare Regulatory Requirements Appendix conflicts with a provision of the Tennessee Program Network Provider Agreement and/or Exhibit A, the TennCare Regulatory Requirements Appendix shall prevail.
XXI. Glossary of Terms Appendix

**Behavioral Health Care Advocate** - Trained clinical staff who support the member toward wellness through care coordination, removing barriers to accessing care, and managing behavioral health care needs, benefits and services.

**Crisis Respite Services (Behavioral Health)** – Behavioral health services intended to provide immediate shelter to individuals with emotional/behavioral problems who are in need of emergency respite.

**Crisis Services (Behavioral Health)** – Behavioral health services rendered to individuals who present with emotional/behavioral problems when there is a perception of crisis by the individuals, their family members, law enforcement, providers, or others. Behavioral health crises can be either urgent in nature or emergencies. An urgent condition is an acute onset of a behavioral health related condition, not constituting an immediate substantial likelihood of harm, but if left untreated, the condition may deteriorate into a behavioral health emergency or cause the individual unnecessary anxiety. A behavioral health emergency is an acute onset of a behavioral health condition that manifests itself by an immediate substantial likelihood of serious harm as evidenced by one or more of the following:

1. Threatened or attempted suicide or serious bodily harm;
2. Threatened or attempted homicide or violent behavior;
3. Placed others in reasonable fear of violent behavior and serious physical harm; and/or
4. The individual is unable to avoid severe impairment of injury from specific risks.

**Emergency Medical Condition** – A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**EPSDT** – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA ’89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population. The Federal regulations for EPSDT are in 42 CFR Part 441, Subpart B.

**Exclusions** – Specific conditions or circumstances listed in the Medicaid/Standard Rules for which the TennCare plan will not provide coverage reimbursement.

**Healthcare Effectiveness Data and Information Set (HEDIS)** – The most widely used set of standardized performance measures used in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance.
HIPAA – Health Insurance Portability and Accountability Act.

Least restrictive level of care – The Level of Care at which the patient can be safely and effectively treated while maintaining maximum independence of living.

Medically Necessary Services – A medical item or service that meets the criteria set forth in TCA, Section 71-5-144. To be medically necessary, a medical item or service must satisfy each of the following criteria:

1. It must be recommended by a licensed physician who is treating the member or other licensed healthcare provider practicing within the scope of his or her license who is treating the member
2. It must be required in order to diagnose or treat a member’s medical condition
3. It must be safe and effective
4. It must not be experimental or investigational
5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the member’s medical condition

Mental Health Services – The diagnosis, evaluation, treatment, residential care, rehabilitation, counseling or supervision of persons who have a mental illness.

Mental Health Case Management – Mental health case management is a supportive service provided to enhance treatment effectiveness and outcomes with the goal of maximizing resilience and recovery options and natural supports for the individual. Mental health case management is consumer-centered, consumer focused and strength-based, with services provided in a timely, appropriate, effective, efficient and coordinated fashion. It consists of activities performed by a team or a single mental health case manager to support clinical services. Mental health case managers assist in ensuring the individual/family access to services.

National Committee for Quality Assurance (NCQA) – A nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.

Non-Allowed Charges – medical charges for which Contracting Provider is not permitted to receive payment from UHCCP and cannot bill the member. Examples are:

1. The difference between billed charges and contracted rates and
2. Charges for services that are bundled or unbundled as detected by Correct Coding Initiative edits.

Non-Covered Services – services for which benefits are not payable in accordance with the Medicaid waivers under Section 1915(c) of the Social Security Act or by UHCCP and for which the member is financially responsible. Exception is that once a Provider bills UHCCP for a non-covered service, the member is no longer responsible for payment.
Primary Care Provider (PCP) – A primary care physician or other licensed health provider practicing in accordance with state law who is responsible for providing preventive and primary health care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A PCP may practice in various settings such as local health departments, FQHCs or community mental health agencies (CMHAs) provided that the PCP is willing and able to carry out all PCP responsibilities. A primary care physician is generally a physician who has limited his/her practice of medicine to general practice or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Geriatrician, or Family Practitioner.

Prior Authorization – The act of authorizing specific services or activities before they are rendered or occur.

Priority Member – A TennCare member who has been identified by TennCare as vulnerable due to certain mental health diagnoses.

Provider – An institution, facility, physician, or other health care practitioner that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished.

Provider Agreement – An agreement, using the provider agreement template approved by TDCI, between UHCCP and a provider or between subcontractors and a provider that describes the conditions under which the provider agrees to furnish covered services to UHCCP members.

Quality assurance – A formal set of activities to review and affect the quality of services provided. Quality assurance includes assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient services. Federal and state regulations typically require plans to have quality assurance programs.

Quality improvement – A continuous process that identifies opportunities for improvement in healthcare delivery, tests solutions, and routinely monitors solutions for effectiveness.

Recovery – 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 despite a disability.

Resilience – A dynamic developmental process for children and adolescents 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.

Substance Abuse Services – The assessment, diagnosis, treatment, detoxification, residential care, rehabilitation, education, training, counseling, referral or supervision of individuals who are abusing or have abused substances.

Supported employment – consists of a range of services 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 a variety of support services to the individual, including side-by-side support on the job. These services may be integrated into a psychosocial rehabilitation center.

Post-stabilization Care Services – Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e), to improve or resolve the member’s condition.
**Supported housing services** – refers to facilities staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports in a highly structured setting. These facilities are for priority members and are not residential treatment facilities. Supported housing is intended to prepare individuals for more independent living in the community while providing an environment that allows individuals to live in community settings with appropriate mental health supports. Given this goal, every effort should be made to place individuals near their families and other support systems and original areas of residence. Supported housing does not include the payment of room and board.
XXII. Forms Appendix

Acknowledgement of Hysterectomy Form -- English
Behavioral Health Adverse Occurrence/Sentinel Event Reporting Form
Behavioral Health Discharge Instructions Form
Behavioral Health Discharge Plan Requirements
Behavioral Health Discharge Summary
Certificate of Medical Necessity for Abortion - English
Certificate of Medical Necessity for Abortion - Spanish
Certificate of Medical Necessity for Transportation - Middle & East
Certificate of Medical Necessity for Transportation - West
CHOICES Critical Incident Reporting Form
CHOICES EVV Registration Form
CHOICES HCBS Provider Application
CHOICES HCBS Provider Change Form
CHOICES Provider Requirements Standards Assessment and Documentation
Review Form Declaration of Mental Health Treatment Form
Discrimination Complaint Form
Disclosure Form for a Provider Person
Disclosure Form for Provider Entities
Grier Appeal Poster -- English & Spanish
Healthy First Steps Enrollment Form
Member Appeal Form -- English
Member Appeal Form -- Spanish
PCP Change Request Form
Physician and Provider Demographic Change Submission Form
Prior Authorization Fax Request Form
Provider Dispute Form
Provider Initiation Notice (PIN) Guide
Provider Quick Reference Guide
Recoup Request Form
Sterilization Consent Form - English
Sterilization Consent Form -- Spanish
TennCare Kids Screening Examination Forms
Unfair Treatment Form (English)
Unfair Treatment Form (Spanish)
Unfair Treatment Complaint Form (English)
Unfair Treatment Complaint Form (Spanish)
THIS TENNCARE PROGRAM REGULATORY REQUIREMENTS APPENDIX (this “Appendix”) supplements and is made part of the provider agreement (the “Agreement”) between UnitedHealthcare Healthcare Insurance Company or one of its Affiliates and the party named in the Agreement (“Provider”).

SECTION 1
APPLICABILITY

The requirements of this Appendix apply to State of Tennessee Medicaid Program benefit plans sponsored, issued or administered by UnitedHealthcare Healthcare Plan of the River Valley, Inc. (referred to in this Appendix as “UnitedHealthcare”) under the TennCare program (“TennCare”) as governed by the State’s designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event UnitedHealthcare is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that UnitedHealthcare shall be permitted to unilaterally initiate such additions, deletions or modifications through an amendment to the Provider’s Agreement.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable CRA, the definitions shall have the meaning set forth under the applicable CRA.

2.1 **Affiliate:** Those entities controlling, controlled by, or under common control with UnitedHealthcare Healthcare Insurance Company. For purposes of this Appendix and Agreement, such Affiliates may be referred to as UnitedHealthcare Healthcare Plan of the River Valley, Inc., UPRV, River Valley Plan and UnitedHealthcare Healthcare Community Plan.

2.2 **Bureau of TennCare:** The division of the Tennessee Department of Finance and Administration (the single state Medicaid agency) that administers TennCare. For the purposes of the State Contract, the Agreement and this Appendix, Bureau of TennCare shall mean the State of Tennessee and its representatives.

2.3 **Care Coordinator:** The individual who has primary responsibility for performance of care coordination activities for a TennCare Covered Person receiving long term care services as specified in this Appendix and meets the qualifications specified in the CRA.

2.4 **Contractor Risk Agreement (CRA) or State Contract:** The agreement between UnitedHealthcare and Bureau of TennCare regarding requirements for operation and administration for the managed care TennCare program, including CHOICES, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare. Each Grand Region in the State is ruled by a separate specific CRA. Should any contract terms vary between the CRAs, each Grand Region shall be ruled by the applicable CRA for that Grand Region.
2.5 **Covered Person:** A person who has been determined eligible for TennCare and who has been enrolled with UnitedHealthcare for the provision of Covered Services under TennCare. A Covered Person may also be referred to as an Enrollee, Member, Customer or Patient under the Agreement.

2.6 **Covered Services:** The package of health care services, including physical health, behavioral health, and long-term care services, that define the covered services or benefits available to TennCare Enrollees enrolled with UnitedHealthcare pursuant to the State Contract.

2.7 **CHOICES Home and Community-Based Services (CHOICES HCBS):** Services that are available only to eligible persons enrolled in CHOICES Group 2 or Group 3 as an alternative to long-term care institutional services in a nursing facility or to delay or prevent placement in a nursing facility. Only CHOICES HCBS are eligible for Consumer Direction. CHOICES HCBS do not include home health or private duty nursing services or any other HCBS that are covered by Tennessee’s Title XIX state plan or under the TennCare demonstration for all eligible enrollees, although such services are subject to estate recovery and shall be counted for purposes of determining whether a CHOICES member’s needs can be safely met in the community within his or her individual cost.

2.8 **Medical Records:** All medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; records of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

2.9 **Patient Liability:** The amount of a Covered Person’s income, as determined by the Tennessee Department of Human Services (DHS), to be collected each month to help pay for the Covered Person’s long-term care services.

2.10 **Provider Manual:** The TennCare Program Provider Manual is the administrative guide for providers that includes additional information, protocols and UnitedHealthcare policies. The Provider Manual is available on the website at www.uhccommunityplan.com.

2.11 **State:** The State of Tennessee, including, but not limited to, any entity or agency of the state, such as the Tennessee Department of Finance and Administration, the Office of Inspector General, the Bureau of TennCare, the Tennessee Bureau of Investigation, Medicaid Fraud Control Unit, the Tennessee Department of Mental Health and Developmental Disabilities, the Tennessee Department of Children’s Services, the Tennessee Department of Health, the Tennessee Department of Commerce and Insurance, and the Office of the Attorney General or any other designated regulatory agencies.

2.12 **State Contract or Contractor Risk Agreement (CRA):** The agreement between UnitedHealthcare and Bureau of TennCare regarding requirements for operation and administration of the managed care TennCare program, including CHOICES, for the purpose of providing and paying for Covered Services to Covered Persons enrolled in TennCare. Each Grand Region in the State is ruled by a separate specific CRA. Should any contract terms vary between the CRAs, each Grand Region shall be ruled by the applicable CRA for that Grand Region. The CRA is available to the Provider on the Bureau of TennCare website at http://www.tn.gov/tenncare/topic/providers-managed-care-organizations.

2.13 **TennCare:** The program administered by the Bureau of TennCare, as designated by the State and the Centers for Medicare and Medicaid Services (CMS), pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

2.14 **TennCare CHOICES in Long-Term Care (CHOICES):** A program in which long-term care services for elders and/or persons with physical disabilities are integrated into TennCare’s managed care delivery system.
2.15 TennCare Kids (EPSDT): The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State’s Medicaid plan to the rest of the Medicaid population. The federal regulations of EPSDT are in 42 CFR Part 441, Subpart B.

SECTION 3 PROVIDER REQUIREMENTS

The TennCare program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that UnitedHealthcare and Provider agree to undertake, which include the following:

3.1 Provision of Covered Services. Provider may not refuse to provide Medically Necessary or preventive Covered Services to a child under the age of twenty-one (21) or other Covered Persons for non-medical reasons. Provider is not required to accept or continue treatment of a patient with whom Provider feels he or she cannot establish and/or maintain a professional relationship. Provider shall follow the applicable CRA’s requirements for the provision of Covered Services. Provider’s decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered Services (inpatient and outpatient) that are as follows: (1) furnished by a provider that is qualified to furnish these services; and (2) needed to evaluate or stabilize an emergency medical condition. UnitedHealthcare shall provide coverage for an Emergency Medical Condition and any necessary Emergency Services, and Emergency Services shall be rendered by Provider without a requirement of prior authorization of any kind.

(c) Medically Necessary: Shall be defined by Tennessee Code Annotated, Section 71-5-144, and shall describe a medical item or service that meets the criteria set forth in that statute. The term “medically necessary”, as defined by Tennessee Code Annotated, Section 71-5-144, applies to TennCare enrollees. Implementation of the term “medically necessary” is provided for in regulations at 1200-13-16, consistent with the statutory provisions, which control in case of ambiguity. No enrollee shall be entitled to receive and TennCare shall not be required to pay for any items or services that fail fully to satisfy all criteria of “medically necessary” items or services, as defined either in the statute or in regulations at 1200-13-16.

3.2 Non-Covered Services. As specified in section A.2.10 of the CRA, Provider acknowledges and agrees that, except as authorized pursuant to section A.2.6.5 of the CRA, and in accordance with applicable the Bureau of TennCare rules and regulations at 1200.13.13.10 and 1200.13.14.10, UnitedHealthcare shall not pay for non-Covered Services.

3.3 Scope of Practice/Services. By signing the Agreement, Provider certifies that Provider shall provide to Covered Persons only the Covered Services specified in the Agreement and that such services are within the scope of Provider’s professional/technical practice.

3.4 Medicaid Eligibility; NPI. Provider must meet applicable minimum requirements for participation in TennCare, including a State Medicaid ID number as required by the Bureau of TennCare, and as applicable, Provider shall obtain a National Provider Identification Number (NPI).
3.5 **Accessibility Standards.** Provider shall comply with applicable access requirements, including but not limited to appointments and wait times, established under the CRA, as further described in the Provider Manual.

3.6 **Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries.

3.7 **Hold Harmless.** As specified in section A.2.6.7 of the CRA, Provider or collection agencies acting on Provider’s behalf may not bill Covered Persons for amounts other than applicable TennCare cost sharing or Patient Liability amounts for Covered Services, including but not limited to, services that the State or UnitedHealthcare has not paid for, except as permitted by the Bureau of TennCare rules and regulations and as described below. Providers may seek payment from a Covered Person only in the following situations:

(a) If the services are not Covered Services and, prior to providing the services, Provider informed Covered Person that the services are not Covered Serves. Provider shall inform the Covered Person of the non-Covered Service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgment in writing prior to rendering the service. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once Provider bills UnitedHealthcare for the service that has been provided, the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

(b) If the Covered Person’s TennCare eligibility is pending at the time services are provided and if Provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively. Regardless of any understanding worked out between Provider and the Covered Person about private payment, once the provider bills UnitedHealthcare for the service the prior arrangement with the Covered Person becomes null and void without regard to any prior arrangement worked out with the Covered Person;

(c) If the Covered Person’s TennCare eligibility is pending at the time services are provided, however, all monies collected, except applicable TennCare cost sharing or Patient Liability amounts shall be refunded when a claim is submitted to UnitedHealthcare because Provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established. (The monies collected shall be refunded as soon as a claim is submitted and shall not be held conditionally upon payment of the claim); and

(d) If the services are not covered because they are in excess of the Covered Person’s benefit limit, and Provider complies with applicable TennCare rules and regulations.

As a condition of payment, Provider shall accept the amount paid by UnitedHealthcare or appropriate denial made by UnitedHealthcare (or, if applicable, payment by UnitedHealthcare that is supplementary to the Covered Person’s third party payer) plus any applicable amount of TennCare cost sharing or Patient Liability responsibilities due from the Covered Person as payment in full for the service. Except in the circumstances described above, if UnitedHealthcare is aware that Provider, or a collection agency acting on Provider’s behalf, bills a Covered Person for amounts other than the applicable amount of TennCare cost sharing or Patient Liability responsibilities due from the Covered Person, UnitedHealthcare shall notify the Provider and demand that Provider and/or collection agency cease such action against the Covered Person immediately. If Provider continues to bill a Covered Person after notification by UnitedHealthcare, UnitedHealthcare shall refer the provider to the Tennessee Bureau of Investigation. For purposes of this Section 3.7, Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the Covered Person being served. This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.
3.8 **Indemnification.**

(a) Provider shall indemnify and hold harmless the State as well as its officers, agents, and employees (hereinafter the “Indemnified Parties”) from all claims, losses or suits incurred by or brought against the Indemnified Parties as a result of the failure of Provider to comply with the terms of the CRA. The State shall give UnitedHealthcare and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider’s own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to UnitedHealthcare or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

(b) Provider shall indemnify and hold harmless the Indemnified Parties as well as their officers, agents, and employees from all claims or suits which may be brought against the Indemnified Parties for infringement of any laws regarding patents or copyrights which may arise from Provider’s or Indemnified Parties performance under the CRA. In any such action, brought against the Indemnified Parties, Provider shall satisfy and indemnify the Indemnified Parties for the amount of any final judgment for infringement. The State shall give UnitedHealthcare and Provider written notice of each such claim or suit and full right and opportunity to conduct Provider’s own defense thereof, together with full information and all reasonable cooperation; but the State does not accord to UnitedHealthcare or Provider, through its attorneys, any right(s) to represent the State of Tennessee in any legal matter, such right being governed by TCA 8-6-106.

(c) While the State will not provide a contractual indemnification to Provider, such shall not act as a waiver or limitation of any liability for which the State may otherwise be legally responsible to Provider. Provider retains all of its rights to seek legal remedies against the State for losses Provider may incur in connection with the furnishing of services under the Agreement or this Appendix, in accordance with the terms of the CRA, or for the failure of the State to meet its obligations under the CRA.

This section does not apply to governmental entities that are exempt from this indemnification requirement.

3.9 **Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If UnitedHealthcare delegates credentialing to Provider, UnitedHealthcare will provide monitoring and oversight and Provider shall ensure that providers, including Long Term Services and Supports providers and all licensed medical professionals are credentialed in accordance with UnitedHealthcare’s and the CRA’s credentialing requirements.

3.10 **Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider’s family has a financial relationship, pursuant to federal anti-kick back and physician self-referral laws that prohibit such referrals.

3.11 **Subcontracts.** Provider shall not enter into subsequent agreements or subcontracts for any of the work contemplated under the Agreement or this Appendix without the prior written approval of UnitedHealthcare. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the CRA. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by UnitedHealthcare, to meet any additional TennCare requirements that may apply to the services. Provider agrees and acknowledges that subcontracts require prior approval by the Bureau of TennCare and Tennessee Department of Commerce and Insurance (TDCI).
In the event Provider does not obtain approval from UnitedHealthcare to enter into subsequent agreements or subcontracts, those subsequent agreements and/or subcontracts may be declared null and void by the Bureau of TennCare and claims submitted for such services shall be considered improper payments and may be considered false claims. Any such improper payment may be subject to action under Federal and State false claims statute or be subject to recoupment by UnitedHealthcare and/or Bureau of TennCare as overpayments.

3.12 Records Retention. As required under State or federal law or the CRA, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Provider shall have and maintain documentation necessary to demonstrate that Covered Services were provided in compliance with State and federal requirements. Such records shall be maintained for five (5) years from the close of the Agreement, with the exception of behavioral health records, which, as applicable, shall be maintained by Provider for ten (10) years after the termination of the Agreement in accordance with TCA 33-3-101, or such other periods required by law. If records are under evaluation, audit, review, investigation or prosecution, they must be retained until the evaluation, audit, review, investigation or prosecution is completed for recording Covered Services, servicing providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Covered Persons pursuant to the Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of Covered Services performed under the Agreement and administrative, civil or criminal investigations or prosecutions).

(a) Medical Records. Provider shall maintain Medical Records in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Provider shall develop and maintain Medical Record keeping policies and practices which are consistent with 42 CFR Part 456 and current NCQA standards for Medical Record documentation. Provider shall distribute these policies to any additional practice sites. At a minimum, the policies and procedures shall address:

(i) confidentiality of Medical Records;
(ii) Medical Record documentation standards; and
(iii) the Medical Record keeping system and standards for the availability of Medical Records. At a minimum the following shall apply: (1) as applicable, Medical Records shall be maintained or available at the site where Covered Services are rendered; (2) Covered Persons (for purposes of behavioral health records, Covered Person includes an individual who is age sixteen (16) or over) and their legally appointed representatives shall be given access to the Covered Person’s Medical Records, to the extent and in the manner provided by TCA 63-2-101, 63-2-102 and 33-3-104 et seq., and, subject to reasonable charges, (except otherwise provided in the CRA) be given copies thereof upon request; (3) provisions for ensuring that, in the event a Covered Person-provider relationship with a TennCare PCP ends and the Covered Person requests that medical records be sent to a second TennCare provider who will be the Covered Person’s PCP, the first provider does not charge the Covered Person or the second provider for providing the Medical Records; and (4) performance goals to assess the quality of Medical Record keeping.

(b) Behavioral Health Providers. As applicable, behavioral health providers shall maintain Medical Records in conformity with TCA 33-3-101 et seq. for persons with serious emotional disturbance or mental illness. Behavioral health providers shall also maintain Medical Records of persons whose confidentiality is protected by 42 CFR Part 2 in conformity with that rule or TCA 33-3-103, whichever is more stringent.

(c) General Record Keeping; Audit or Investigation. Provider acknowledges and agrees that the Bureau of TennCare, Department of Health and Human Services Office of Inspector General (DHHS OIG), Office of the Comptroller of the Treasury, Tennessee Bureau of Investigation, Medicaid Fraud Control Unit (TBI MFCU), Office of Inspector General (OIG) and Department of Justice (DOJ), as well as any authorized State or federal agency or entity or their
authorized representatives may evaluate through inspection, evaluation, review or request, whether announced or unannounced, or other means any records pertinent to the Agreement, including, but not limited to, Medical Records, billing records, financial records, and/or any records related to services rendered, quality, appropriateness and timeliness of services, and/or any records relevant to an administrative, civil and/or criminal investigation and/or prosecution and such evaluation, inspection, review or request, and when performed or requested, shall be performed with the immediate cooperation of Provider. Upon request, Provider shall assist in such reviews, including the provision of complete copies of Medical Records. Any authorized State or federal agency or entity, including, but not limited to, the Bureau of TennCare, OIG, TBI MFCU, DHHS OIG, DOJ, and Office of the Comptroller of the Treasury, may use these records and information for administrative, civil or criminal investigations and prosecutions. For purposes of clarity with respect to this Section, HIPAA does not bar disclosure of protected health information (PHI) to health oversight agencies, including, but not limited to, OIG, TBI MFCU, DHHS OIG and DOJ.

3.13 Availability of Records. Provider acknowledges and agrees that the Bureau of TennCare representatives and authorized federal, state and Office of the Comptroller of the Treasury personnel, including, but not limited to TennCare, the Office of the Inspector General (OIG), the Tennessee Bureau of Investigations, Medicaid Fraud Control Unit (TBI MFCU), the Department of Health and Human Services, Office of Inspector General (DHHS OIG) and the Department of Justice (DOJ), and any other duly authorized state or federal agency shall have immediate and complete access to all records pertaining to services provided to Covered Persons as specified in section A.2.25.5 of the CRA.

3.14 Government Inspection. Provider shall make all records (including but not limited to, financial, administrative and Medical Records) available at Provider’s expense for administrative, civil and/or criminal review, audit, or evaluation, inspection, investigation and/or prosecution by authorized federal, state, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, the Bureau of TennCare or any duly authorized state or federal agency, upon any authorized government agency’s request. Any authorized government agency, including but not limited to OIG, TBI MFCU, DHHS OIG and DOJ, may use these records to carry out their authorized duties, reviews, audits, administrative, civil and/or criminal investigations and/or prosecutions. Access will be either through on-site review of records or through the mail at the government agency’s discretion and during normal business hours, unless there are exigent circumstances, in which case access will be at any time. Provider shall send all records to be sent by mail to the Bureau of TennCare within twenty (20) business days of request unless otherwise specified by the Bureau of TennCare or applicable TennCare rules and regulations. Requested records shall be provided at no expense to the Bureau of TennCare, authorized federal, State, and Office of the Comptroller of the Treasury personnel, including representatives from the OIG, the TBI MFCU, DOJ and the DHHS OIG, or any duly authorized State or federal agency. Records related to appeals shall be forwarded within the time frames specified by in the appeal process portion of the CRA. Provider acknowledges and agrees that such requests made by TennCare shall not be unreasonable. Records shall be provided by Provider to the requesting agency at no cost.

As a condition of participation in TennCare, Covered Persons and Provider shall give TennCare or its authorized representative, the Office of the Comptroller of the Treasury, and any health oversight agency, such as OIG, TBI MFCU, DHHS Office of Inspector General (DHHS OIG), and DOJ, and any other authorized state or federal agency, access to their records. Provider shall furnish, immediately upon request, said records for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring as well as for administrative, civil and criminal investigations or prosecutions.

3.15 Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to the Agreement, as well as medical information relating to the Covered Persons as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in the CRA. Records other than Medical Records may be kept in an original paper state or preserved on micromedia or electronic format. Medical Records shall be maintained
in their original form or may be converted to electronic format as long as the records are readable and/or legible. These records, books, documents, etc., shall be available for any authorized federal, state, including, but not limited to TennCare, OIG, TBI MFCU, DOJ and the DHHS OIG, and Office of the Comptroller of the Treasury personnel during the Agreement period and five (5) years thereafter, unless an audit, administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are yet unresolved in which case records shall be kept until all tasks or proceedings are completed. During the CRA contract period, these records shall be available at Provider’s chosen location in Tennessee subject to the written approval of UnitedHealthcare and TennCare. If the records need to be sent to TennCare, UnitedHealthcare shall bear the expense of delivery. Prior approval of the disposition of Provider’s records must be requested and approved by TennCare in writing.

3.16 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, CRA sections A.2.27 (HIPAA) and E.6 (Confidentiality), as may be amended from time to time. Provider and its employees, providers, agents and subcontractors shall maintain reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of all protected health information (“PHI”) it receives or possesses in the course of carrying out the responsibilities of the Agreement.

3.17 Compliance with Law. Provider shall comply with and this Agreement incorporates by reference all applicable federal and State laws including Bureau of TennCare rules and regulations, guidelines, consent decrees or court orders; and revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the Agreement as they become effective, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Americans with Disabilities Act, and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.


(d) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

3.18 Physician Incentive Plans. In the event Provider participates in a physician incentive plan (“PIP”) under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither UnitedHealthcare nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. All PIPs must receive prior approval from the Bureau of TennCare and TDCI.
3.19 **Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

(a) **Prohibition on Use of Federal Funds for Lobbying:** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) **Disclosure Form to Report Lobbying:** Provider shall disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

3.20 **Conflict of Interest.** Provider shall cooperate with UnitedHealthcare’s policies and procedures and comply with section E.28 of the CRA related to detecting and preventing conflicts of interest from occurring at all levels.

3.21 **Gratuities.** By signing the Agreement, Provider certifies that no member of or delegate of Congress, nor any elected or appointed official or employee of the State, the United States General Accounting Office, DHHS, CMS, or any other federal agency has or will benefit financially or materially due to influence in obtaining the Agreement. The Agreement may be terminated by TennCare if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from Provider or its agent or employees.

3.22 **Excluded Individuals and Entities.** By signing the Agreement, Provider certifies that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement are:

(a) excluded from participation in federal health care programs under either Sections 1128 or 1156 of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

(c) are otherwise not in good standing with TennCare.

Provider is obligated to screen its employees and contractors (“Screened Persons”) initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded, debarred, suspended or otherwise ineligible to participate in Federal Health Care Programs or convicted of a criminal offense that falls within the realm of 42 U.S.C. § 1320a-7(a) (“Ineligible Persons”). Provider shall immediately report to UnitedHealthcare any
exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons. Provider can search the lists of excluded individuals (the “Exclusion Lists”) on the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases: LEIE at http://www.oig.hhs.gov/fraud/exclusions.asp.; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov and the Excluded Parties List Serve (EPLS)http://www.epls.gov. UnitedHealthcare will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

If Provider determines that a Screened Person has become and Ineligible Person, then Provider will take appropriate action to remove such Screened Person from responsibility for, or involvement with, Provider's professional or business operations related to the Federal Health Care Programs and shall remove such Screened Person from any position for which the Screened Person's compensation or the items or services furnished, ordered, or prescribed by the Screened Person are paid in whole or part, directly or indirectly, by Federal Health Care Programs or otherwise with Federal funds at least until such time as the Screened Person is reinstated into participation in the Federal Health Care Programs. Any unallowable Federal funds made to an excluded individual as full or partial wages and/or benefits shall be refunded to UnitedHealthcare and/or the State, as applicable.

If Provider determined that a Screened Person is an Ineligible Person charged with a criminal offense that falls within the scope of 42 U.S.C. §§ 1320a-7(a) or is proposed for exclusion during the Screened Person’s employment or contract term, Provider shall take all appropriate actions to ensure that the responsibilities of that Screened Person have not and shall not adversely affect the quality of care rendered to any beneficiary, patient, or resident, or any claims submitted to any Federal Health Care Program.

3.23 Background Checks. Provider shall conduct background checks in accordance with State law and TennCare policy.

3.24 Disclosure. Provider shall comply and submit to UnitedHealthcare disclosure of information in accordance with the requirements, including timeframes, specified in 42 C.F.R. Part 455, Subpart B and TennCare policies and procedures. The timeframes for this requirement shall include, at a minimum, at the time of initial contracting, contract renewal, at any time there is a change to any of the information on the disclosure form, at least once every three (3) years, and at anytime upon request.

3.25 Cultural Competency, Language Services and Nondiscrimination Investigation. Provider shall participate in UnitedHealthcare’s and the State’s efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those individuals with disabilities, with limited English proficiency and diverse cultural and ethnic backgrounds. Provider shall provide information to Covered Persons regarding treatment options and alternatives in a manner appropriate to the Covered Person’s condition and ability to understand and shall have written procedures for the provision of language interpretation and translation services for any Covered Person who needs such services. Provider further agrees to cooperate with the Bureau of TennCare and UnitedHealthcare during any discrimination complaint investigation and Provider shall assist Covered Persons with obtaining discrimination compliant forms and contact information for UnitedHealthcare’s nondiscrimination office.

3.26 Marketing. As required under State or federal law or the applicable CRA, any marketing materials developed and distributed by Provider as related to the performance of the Agreement, and any materials distributed to Covered Persons that use TennCare’s name or trademark, must be submitted to UnitedHealthcare to submit to the Bureau of TennCare for prior approval. This prohibition shall not include references to whether or not the provider accepts TennCare.

3.27 Fraud, Waste and Abuse Prevention. As a condition of payment, Provider shall comply with section A.2.20 of the CRA and shall cooperate fully with the State’s and UnitedHealthcare’s policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and
delivery of services under the CRA and shall cooperate and assist the Bureau of TennCare and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and/or federal health care programs.

In accordance with UnitedHealthcare’s policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider’s policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.28 Reports. Provider shall timely submit all reports and clinical information required by UnitedHealthcare including, but not limited to, information needed for purposes of making medical necessity determinations. Providers who do not provide requested medical information for purposes of making medical necessity determinations for a particular item or service shall not be entitled to payment for the provision of such item or service.

3.29 Mandatory Reporting of Abuse. Provider shall report suspected abuse, neglect, and exploitation of adults in accordance with TCA 71-6-103 and report suspected brutality, abuse, or neglect of children in accordance with TCA 37-1-403 and TCA 37-1-605.

3.30 TennCare Children. Provider shall not encourage or suggest, in any way, that TennCare children be placed into state custody in order to receive medical, behavioral, or long-term care Covered Services.

3.31 Claims Information. UnitedHealthcare shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and the CRA, as may be amended from time to time.

(a) Payment. Provider shall promptly submit to UnitedHealthcare information needed to make payment. Provider shall have one hundred twenty (120) calendar days from the date of rendering a Covered Service to file a claim with UnitedHealthcare, except (1) in situations regarding coordination of benefits or subrogation, in which case Provider is pursuing payment from a third party or (2) if a Covered Person is enrolled in UnitedHealthcare with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim. In situations of enrollment in UnitedHealthcare with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that UnitedHealthcare receives notification from the Bureau of TennCare of the Covered Person’s eligibility/enrollment.

(b) Denial. The TennCare Provider Independent Review of Disputed Claims process shall be available to Provider to resolve claims denied in whole or in part by UnitedHealthcare as provided in TCA 56-32-126(b).

3.32 Capitation Payments. If Provider is compensated via a capitation arrangement, Provider must:

(a) Immediately notify UnitedHealthcare and the Bureau of TennCare by certified mail, return receipt requested, if Provider becomes aware for any reason that he or she is not entitled to capitation payment for a particular Covered Person (for example, if an Covered Person dies); and

(b) Submit utilization or encounter data as specified by UnitedHealthcare so as to ensure UnitedHealthcare’s ability to submit encounter data to the Bureau of TennCare that meets the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.
3.33 **Overpayments.** Provider shall notify UnitedHealthcare of any overpayments in compliance with the Affordable Care Act and TennCare policy and procedures. When applicable, Provider shall return such overpayment within sixty (60) days from the date the overpayment is identified. Overpayments that are not returned within sixty (60) days from the date the overpayment was identified may result in a penalty pursuant to State or federal law.

3.34 **Health Care-Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by TennCare. As a condition of payment, Provider shall identify and report to UnitedHealthcare and TennCare any provider-preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.35 **Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by TennCare or UnitedHealthcare is conditioned upon the claim and the underlying transaction complying with such laws, Regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law and federal requirements on disclosure, debarment and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to TennCare or to UnitedHealthcare constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), in connection with such claims and the services provided therein.

3.36 **Insurance Requirements.** Provider shall secure and maintain during the term of the Agreement, as applicable, general liability insurance and professional liability insurance. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by UnitedHealthcare pursuant to the Agreement or as required under the CRA. Provider shall furnish UnitedHealthcare with written verification of the existence of such coverage prior to execution of the Agreement.

If Provider is a Tennessee State Agency, Provider shall not be required to provide, carry or maintain general liability insurance or medical, professional or hospital liability insurance in accordance with Title 9, Chapter 8 of the Tennessee Code Annotated. Claims against the State, or its employees, for injury, damages, expenses or attorney fees are heard and determined by the Tennessee Claims Commission or the Tennessee Board of Claims in the manner prescribed by law.

If Provider is a Local Governmental Entity as set out under the Governmental Tort Liability Act in TCA 29-20-101, et seq., and as such, has its liability limits defined by law: As a Local Governmental Entity, Provider carries no insurance; however, it is self-insured for general liability in an adequately funded Self-Insurance Program up to the limits as set out in the statute. This self-insurance is for the benefit of the Local Governmental Entity only and provides no indemnification for any other entity whatsoever. The Local Governmental Entity does not have the authority under current law to indemnify other parties. The Local Governmental Entity agrees to produce proof of adequate professional liability insurance for Provider’s professional employees who perform any professional services under this Agreement.

For a Provider rendering Long Term Care Choices Nursing Facility services and/or Home and Community Based Services, that is not a Local Governmental Entity or a State Agency, and does not provide short term skilled services:

For three (3) years following the effective date of TennCare’s Long Term Care Benefit Plan (“CHOICES HCBS”) implementation (the “Implementation Period”), UnitedHealthcare shall not require Provider to have liability insurance in excess of the TennCare requirements in effect prior to the Implementation Period. At the end of the Implementation Period, this Section shall automatically be amended without further action of the parties to reflect the current CHOICES HCBS insurance requirements. If CHOICES HCBS has not implemented insurance requirements upon expiration of the Implementation Period, the parties agree to reevaluate and replace this paragraph with the then standard insurance requirements for similar providers. At all times, Provider agrees to maintain and
provide written proof upon execution of the Agreement and at any subsequent time upon request of UnitedHealthcare of adequate insurance in such amounts as required by this paragraph. Provider agrees to notify UnitedHealthcare not less than fifteen (15) days prior to any reduction in coverage, cancellation or nonrenewal of the policy(s). The insurance required by this section shall not relieve or release Provider from, or limit its liability with respect to, any and all obligations under this Agreement.

3.37 **Quality; Utilization Management.** Provider agrees to participate and cooperate with any quality improvement, utilization review, and management activities established by UnitedHealthcare and/or the Bureau of TennCare, including actions to improve patient safety and quality. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by UnitedHealthcare or as required under the applicable CRA to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by UnitedHealthcare or Provider.

3.38 **Continuity of Care.** To the extent required by applicable law, regulations or the CRA, Provider shall cooperate with UnitedHealthcare and provide Covered Persons with continuity of treatment (which may include coordination of care as required under law) in the event Provider’s participation with UnitedHealthcare terminates during the course of a Covered Person’s treatment by Provider.

3.39 **Emergency Appeals.** UnitedHealthcare will provide general and targeted education to Provider regarding emergency appeals, including when an emergency appeal is appropriate, and procedures for providing written certification thereof. Provider shall comply with the appeal process, including, but not limited to, the following:

(a) Provider must assist a Covered Person by providing appeal forms and contact information including the appropriate address, telephone number and/or fax number for submitting appeals for state level review; and

(b) Provider must seek advance prior authorization when Provider feels he or she cannot order a drug on the TennCare PDL. Further, Provider shall take the initiative to seek prior authorization or change or cancel the prescription when contacted by a Covered Person or pharmacy regarding denial of a pharmacy service due to system edits (e.g., therapeutic duplication, etc.).

3.40 **Public Notices.** Provider shall display public notices of Covered Persons’ rights to appeal adverse actions affecting Covered Services in public areas of Provider’s facility(ies), in accordance with the Bureau of TennCare rules and regulations, subsequent amendments, or any and all consent decrees and court orders. UnitedHealthcare shall ensure that Provider has a correct and adequate supply of public notices in English and Spanish.

3.41 **No Payment outside U.S.** Provider agrees that all Covered Services to be performed herein shall be performed in the United States of America and Provider agrees that UnitedHealthcare shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America. Furthermore, Provider is prohibited to transfer member data in any form via any medium to any third party beyond the boundaries and jurisdiction of the United States without the prior written consent of UnitedHealthcare.

3.42 **Non-Discrimination.** In performance of obligations under the Agreement and in employment practices, Provider shall not exclude, deny benefits or otherwise subject to discrimination, any persons 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. In addition, Provider shall upon request show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and Enrollees. The Provider agrees to have written procedures for the provision of language assistance services to members and/or the member’s representative. Language assistance services include interpretation and translation services and effective
communication assistance in alternative formats for any member and/or the member’s representative who needs such services, including but not limited to, members with Limited English Proficiency and individuals with disabilities. The Provider agrees to cooperate with TennCare and UnitedHealthcare during discrimination complaint investigations. The Provider agrees to assist TennCare enrollees in obtaining discrimination complaint forms and contact information for UnitedHealthcare’s Nondiscrimination Office.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Prenatal/Obstetric Care.

(a) As applicable to Provider, unreasonable delay in providing care to a pregnant Covered Person seeking prenatal care shall be considered a material breach of the Agreement. For purposes of this Section 4.1, “unreasonable delay” shall mean failure of the prenatal care provider to meet the appointment availability requirements established under section A.2.11.4 of the CRA, as further described in the provider manual.

(b) As applicable to Provider, as a condition to reimbursement for global procedures codes for obstetric care, Provider shall submit utilization or encounter data as specified by UnitedHealthcare in a timely manner to support the individual services provided.

4.2 Laboratory Services. If Provider performs laboratory services, Provider shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

4.3 CHOICES Program. If Provider renders Covered Services to Covered Persons under TennCare’s program for long-term care services for elders and/or persons with physical disabilities, Provider shall facilitate notification of the Covered Person’s Care Coordinator by notifying UnitedHealthcare, in accordance with UnitedHealthcare’s processes, as expeditiously as warranted by the Covered Person’s circumstances, of any known significant changes in the Covered Person’s condition or care, hospitalizations, or recommendations for additional services.

4.4 Hospitals. If Provider is a hospital, including a psychiatric hospital, Provider shall cooperate with UnitedHealthcare in developing and implementing protocols as part of UnitedHealthcare’s nursing facility diversion plan, which shall include, at a minimum, a hospital’s obligation to promptly notify UnitedHealthcare upon admission of an eligible Covered Person regardless of payor source for the hospitalization, how a hospital will identify members who may need home health, private duty nursing, nursing facility or HCBS upon discharge, and how a hospital will engage UnitedHealthcare in the discharge planning process to ensure that Covered Persons receive the most appropriate and cost-effective medically necessary services upon discharge.

4.5 Pharmacy Services. Provider shall coordinate with the TennCare pharmacy benefits manager (PBM) regarding authorization and payment for pharmacy services.

4.6 Nursing Facility. If Provider is a nursing facility, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

(a) Promptly notify UnitedHealthcare, and/or the State as directed by the Bureau of TennCare, of a Covered Person’s admission or request for admission to the nursing facility regardless of payor source for the nursing facility stay, or when there is a change in a Covered Person’s known circumstances. Provider shall also notify UnitedHealthcare, and/or the State as directed by TennCare, prior to a Covered Person’s discharge from the nursing facility;

(b) Provide written notice to the Bureau of TennCare and UnitedHealthcare in accordance with State and federal
requirements before voluntarily terminating the Agreement. Provider shall comply with all applicable State and federal
requirements regarding voluntary termination;

(c) Notify UnitedHealthcare immediately if Provider is considering discharging a Covered Person. Provider shall
consult with the Covered Person’s Care Coordinator to intervene in resolving issues if possible. If Provider is not able to
resolve such issues, Provider shall prepare and implement a discharge and/or transition plan as appropriate;

(d) Notify a Covered Person and/or a Covered Person’s representative (if applicable) in writing prior to discharge in
accordance with State and federal requirements;

(e) Provider shall accept payment or appropriate denial made by UnitedHealthcare (or, if applicable, payment by
UnitedHealthcare that is supplementary to the Covered Person’s third party payer) plus the amount of any applicable
Patient Liability, as payment in full for services provided and shall not solicit or accept any surety or guarantee of
payment from a Covered Person in excess of the amount of applicable Patient Liability. For purposes of this Section
4.6(e), Covered Person shall include the patient, parent(s), guardian, spouse or any other legally responsible person of
the Covered Person being served;

(f) Provider’s responsibilities regarding a Covered Person’s Patient Liability as specified in sections A.2.6.7 and A.2.21.5
of the CRA, which shall include but not be limited to collecting the applicable Covered Person Patient Liability
amounts from CHOICES Group 1 members, notifying the Covered Person’s Care Coordinator if there is an issue with
collecting a Covered Person’s Patient Liability, and making good faith efforts to collect payment;

(g) Provider shall timely seek certification and recertification (as applicable) of a Covered Person’s level of care eligibility
for Level I and/or Level II nursing facility care and shall cooperate fully with UnitedHealthcare in the completion and
submission of the level of care assessment;

(h) Provider shall notify UnitedHealthcare of any change in a Covered Person’s medical or functional condition that
could impact the Covered Person’s level of care eligibility for the currently authorized level of nursing facility services;

(i) Provider shall submit complete and accurate Pre-Admission Evaluations (PAEs) to UnitedHealthcare that satisfy all
technical requirements specified by TennCare, and accurately reflect the Member’s current medical and functional
status, including Safety Determination Requests. The nursing facility shall also submit all supporting documentation
required in the PAE and Safety Determination Request Form, as applicable and required pursuant to TennCare Rules.

(j) Provider shall comply with State and federal laws and regulations applicable to nursing facilities as well as any
applicable court orders, including, but not limited to, those that govern admission, transfer, and discharge policies;

(k) Provider shall comply with federal Preadmission Screening and Resident Review (PASRR) requirements applicable
to all CHOICES nursing facility residents, regardless of payor source, including that a level I screening be completed
prior to admission, a level II evaluation be completed prior to admission when indicated by the level I screening, and a
review be completed based upon a significant physical or mental change in the resident’s condition that might impact a
Covered Person’s need for or benefit from specialized services;

(l) Provider shall collaborate with UnitedHealthcare and other providers as needed to help ensure that current
information regarding the Covered Person’s mental health or intellectual disabilities needs (as available) is reflected in
the PASRR screening in order to support an appropriate PASRR determination;

(m) Provider shall cooperate with UnitedHealthcare in developing and implementing protocols as part of
UnitedHealthcare’s CHOICES nursing facility diversion and transition plans, which shall include, at a minimum,
Provider’s obligation to promptly notify UnitedHealthcare upon a admission or request for admission of an eligible
Covered Person regardless of payor source for the CHOICES nursing facility stay, how Provider will assist UnitedHealthcare in identifying residents who may want to transition from CHOICES nursing facility services to CHOICES HCBS; Provider’s obligation to promptly notify UnitedHealthcare regarding all such identified members, and how Provider will work with UnitedHealthcare in assessing a Covered Person's transition potential and needs and in developing and implementing a transition plan (as applicable);

(n) Provider shall coordinate with UnitedHealthcare in complying with the requirements in 42 C.F.R. 483.75, regarding written transfer agreements and shall use contract providers when transfer is medically appropriate, except as authorized by UnitedHealthcare or for emergency services;

(o) Provider shall have on file a system designed and utilized to ensure the integrity of a Covered Person's personal financial resources. This system shall be designed in accordance with the regulations and guidelines set out by the Comptroller of the Treasury and the applicable federal regulations;

(p) Provider shall specify to UnitedHealthcare whether it will be contracted to provide SNF services at an Enhanced Respiratory Care (ERC) rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning in addition to standard NF and SNF services (each level of ERC reimbursement must be uniquely identified). If Provider does enter into an agreement for SNF services at an enhanced rate for ventilator weaning, chronic ventilator care, and/or tracheal suctioning, Provider is required to be licensed by the Tennessee Department of Health to provide such specialized ERC, certified by CMS for program participation, and compliant with threshold standards of care for the applicable type of ERC and requirements for ERC reimbursement established by TennCare.

(q) Provider shall immediately notify UnitedHealthcare of any changes in its license to operate as issued by the Tennessee Department of Health as well as any deficiencies cited during the federal certification process;

(r) If Provider is involuntarily decertified by the Tennessee Department of Health or CMS, the Agreement will be automatically terminated in accordance with federal requirements; and

(s) The Agreement shall be assignable from UnitedHealthcare to the State, or its designee, at the State’s discretion upon written notice to UnitedHealthcare and Provider. Further, Provider agrees to be bound by any such assignment, and the State, or its designee, shall not be responsible for past obligations of UnitedHealthcare.

4.7 CHOICES HCBS Providers. If Provider is a CHOICES HCBS provider, in addition to the other requirements set forth in the Agreement or this Appendix, Provider shall:

(a) Provide at least thirty (30) days advance notice to UnitedHealthcare when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision. Provider shall cooperate with the Covered Person’s Care Coordinator to facilitate a seamless transition to alternate providers;

(b) In the event that a CHOICES HCBS provider change is initiated for a Covered Person, regardless of any other provision of the Agreement, Provider shall continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by UnitedHealthcare, or as otherwise directed by UnitedHealthcare, which may exceed thirty (30) days from the date of notice to UnitedHealthcare, unless the Covered Person is in immediate jeopardy or the Covered Person's health and welfare would be otherwise at risk by remaining with the current provider, or if continuing to provide services is reasonably expected to place staff that would deliver services at imminent risk of harm;

(c) Provider’s reimbursement shall be contingent upon the provision of Covered Services to an eligible Covered Person in accordance with applicable federal and state requirements and the Covered Person's plan of care as authorized by UnitedHealthcare, and must be supported by detailed documentation of service delivery to support the amount
of services billed, including at a minimum, the date, time and location of service, the specific HCBS provided, the
name of the Covered Person receiving the service, the name of the staff person who delivered the service, the detailed
tasks and functions performed as a component of each service, notes for other caregivers (whether paid or
unpaid) regarding the member or his/her needs (as applicable), and the initials or signature of the staff person who
delivered the service;

(d) Provider shall immediately report any deviations from a Covered Person's service schedule to the Covered Person's
Care Coordinator;

(e) Provider shall use the electronic visit verification system specified by UnitedHealthcare in accordance with
UnitedHealthcare's requirements;

(f) Upon acceptance by Provider to provide approved services to a Covered Person as indicated in the Covered Person's
plan of care, Provider shall ensure that it has staff sufficient to provide the service(s) authorized by UnitedHealthcare in
accordance with the Covered Person's plan of care, including the amount, frequency, duration and scope of each service
in accordance with the Covered Person's service schedule;

(g) Provider shall provide back-up for its own staff if a staff member is unable to fulfill an assignment for any reason.
Provider shall ensure that back-up staff meet the qualifications for the authorized Covered Service;

(h) Provider is prohibited from requiring a Covered Person to choose Provider as a provider of multiple services as a
condition of providing any service to the Covered Person;

(i) Provider is prohibited from soliciting Covered Persons to receive services from Provider, including:

   (1) Referring an individual for CHOICES screening and intake with the expectation that, should CHOICES
       enrollment occur, Provider will be selected by the Covered Person as the service provider; or

   (2) Communicating with existing CHOICES members via telephone, face-to-face or written communication for
       the purpose of petitioning the Covered Person to change CHOICES providers;

   (3) Communicating with hospitals, discharge planners or other institutions for the purposes of soliciting
       potential CHOICES members that should instead be referred to the person's MCO, AAAD or DIDD,
       as applicable;

(j) Provider shall comply with critical incident reporting and management requirements specified in section
A.2.15.7 of the CRA;

(k) Provider is not required to have liability insurance in excess of TennCare requirements in effect prior to the
implementation of CHOICES;

(l) Provider may not alter any official CHOICES or MFP brochures or other materials unless prior approval has been
obtained from TennCare in accordance with section A.2.17 of the CRA;

(m) Provider may not reproduce CHOICES or MFP logos for its own use unless prior approval has been obtained
from TennCare; and

(n) Provider is required to submit copies of current licensure and/or certification (as applicable) to UnitedHealthcare.

(o) Provider will maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).
(p) If Provider is utilizing the Electronic Visit Verification (EVV) System, Provider shall ensure that all HCBS workers complete and submit worker surveys upon logging out of each visit using a format and in a manner prior approved by TennCare.

If Provider is a CHOICES HCBS provider who renders PERS, assistive technology, minor home modifications, or pest control services, Provider shall meet all the requirements of the State Contract, the Agreement and this Appendix, applicable to Provider’s services under the Agreement.

4.8 TennCare Kids Services. As applicable to Provider, Provider acknowledges and agrees that Provider is aware of the benefits that TennCare Kids offers and which requires Provider to make treatment decisions based upon children’s individual medical and behavioral health needs, in accordance with the requirements of Section A.2.7.6 of the CRA, which are incorporated into this Appendix and shall be provided to Provider upon request.

4.9 Local Health Department. If Provider is a local health department, Provider shall meet all the requirements of the Agreement and this Appendix (except those that apply to nursing facilities and HCBS providers). In addition, the following apply for the purpose of TennCare Kids screening services:

(a) Provider agrees to timely submit encounter data to UnitedHealthcare;

(b) UnitedHealthcare agrees to timely process claims for services in accordance with CRA Section A.2.22.4;

(c) Provider may terminate the Agreement for cause with thirty (30) days advance notice; and

(d) UnitedHealthcare agrees that prior authorization shall not be required for the provision of TennCare Kids screening services.

4.10 Referrals to Specialty Care Providers. If Provider is a Primary Care Physician (“PCP”), Provider will arrange for referrals to specialty care providers pursuant to the referral policies and procedures as described in the Provider Manual. Providers who are specialty care providers will comply with referral requirements, including but not limited to the following:

(a) Maintain good communications with the Covered Person’s PCP and contact the Covered Person’s PCP if diagnosis or treatment required differs significantly from expectations indicated on the referral form;

(b) Respond in a timely manner to the Covered Person’s PCP with summary of findings, test results, and recommendations following referral;

(c) Notify the Covered Person’s PCP of the need for secondary referral within the TennCare network of physicians. Referral to other physicians outside of the TennCare network should be preceded by consultation and agreement with the Covered Person’s PCP unless in the case of a medical emergency; and

(d) Hospitalize a Covered Person only with the knowledge and agreement of the Covered Person’s PCP or in the case of medical emergency.

4.11 Federal 340B Providers. When applicable, providers participating in the federal 340B program will give UnitedHealthcare the benefit of 340B pricing.

4.12 Ethical and Religious Directives. In the event the Agreement includes a provision limiting the services Provider will provide, the following is applicable:
(a) The Provider shall provide a list to UnitedHealthcare of the services it does not deliver due to the Ethical and Religious Directives. UnitedHealthcare shall furnish this list to the Bureau of TennCare, noting those services that are TennCare covered services. This list shall be used by the UnitedHealthcare and the Bureau of TennCare to provide information to TennCare members about where and how the members can obtain the services that are not being delivered by the Provider due to Ethical and Religious Directives.

(b) At the time of service, the Provider shall inform TennCare members of the health care options that are available to the TennCare members, but are not being provided by the Provider due to the Ethical and Religious Directives, but the Provider is not required to make specific recommendations or referrals. In addition, the Provider shall inform TennCare members that UnitedHealthcare has additional information on providers and procedures that are covered by Bureau of TennCare.

4.13 **Choices CLS and CLS-FM Providers.** If Provider is a Choices CLS or a CLS-FM provider, in addition to the other requirements set forth in the Agreement or this Appendix, the following provision shall apply:

1) Residential Providers, shall develop and maintain policies concerning fire evacuation and natural disasters, including ensuring staff are knowledgeable about evacuation procedures and any available safety equipment (e.g., fire extinguishers).

2) Provider shall routinely monitor the maintenance of a sanitary and comfortable living environment and/or program site, and shall develop and maintain policies for staff to identify and report any individual or systemic problems identified. Additionally, all CLS-FM Providers must complete a DIDD-compliant home study and a current DIDD Family Model Residential Supports Initial Site Survey prior to member placement.

3) Providers with provider-owned vehicles (including employee-owned vehicles used to transport members) shall develop and maintain policies to routinely inspect such vehicles, including adaptive equipment used in such vehicles, and report and resolve any deficiencies with these vehicles.

4) Provider shall designate a staff member as an Incident Management Coordinator who shall be trained on critical incident processes by the UnitedHealthcare as prescribed by TennCare. Such staff member shall be the Provider’s lead for critical incidents, be primarily responsible for tracking and analyzing critical incidents pursuant to Section A.2.15.7.1.2, and be the UnitedHealthcare’s main point of contact at the Provider agency for critical incidents.

5) Provider shall develop and maintain a crisis intervention policy that is consistent with TennCare requirements and approved by UnitedHealthcare. As applicable, policies shall include instructions for the use of psychotropic medications and behavioral safety interventions.

6) Providers shall develop and maintain a complaint resolution process, which includes, but is not limited to the following: designation of a staff member as the complaint contact person; maintenance of a complaint log; and documentation and trending of complaint activity. Provider’s policies and procedures concerning the complaint resolution process shall be available to the UnitedHealthcare upon request.

7) As applicable, Providers providing assistance to a Covered Person with medication administration shall develop and maintain policies to ensure any medications are provided and administered by trained and qualified staff consistent with a physician’s orders. Provider shall ensure that medication administration records are properly maintained, and that all medication is properly stored and accessible to Covered Persons when needed. Such Providers shall also develop and maintain policies to track and trend medication variance and omission incidents to analyze trends and implement prevention strategies.
8) Provider shall develop and maintain policies approved by UnitedHealthcare that ensure Covered Persons are treated with dignity and respect, including training staff on person-centered practices. Such policies shall include, but are not limited to:

a) Ensuring Covered Persons/representatives and family are given the opportunity to participate in the selection and evaluation of their direct support staff, if applicable;

b) Soliciting Covered Person/representative and family feedback on Provider services;

c) Ensuring the Covered Person/representative has information to make informed choices about available services;

d) Ensuring Covered Persons are allowed to exercise personal control and choice related to their possessions;

e) Supporting Covered Persons in exercising their rights;

f) Periodically reviewing Covered Persons' day services and promoting meaningful day activities, if applicable;

g) Supporting the Covered Person in pursuing employment goals; and

h) Only restricting Covered Persons' rights as provided in the Covered Person's person-centered support plan.

9) Residential Providers shall develop and maintain policies to ensure that Covered Persons have good nutrition while being allowed to exercise personal choice and that Covered Persons' dietary and nutritional needs are met.

10) Providers shall ensure that staff have appropriate, job-specific qualifications and shall verify prior to and routinely during employment that Provider staff have all required licensure and certification. Additionally, all Providers shall ensure that staff receives ongoing supervision consistent with staff job functions. Providers shall ensure that the composition of the Provider board of directors or community advisor group, as applicable, reflects the diversity of the community that the Provider serves and is representative of the people served.

11) Residential Providers shall have policies and procedures to manage and protect Covered Persons' personal funds that comport with all applicable UnitedHealthcare and TennCare policies, procedures and protocols.

12) Providers shall carry adequate liability and other appropriate forms of insurance, which shall include, but is not limited to, the following:

a) Workers' Compensation/ Employers' Liability (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability.

b) Comprehensive Commercial General Liability (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.

c) Automobile Coverage (including owned, leased, hired, and non-owned vehicles coverage) with bodily injury/property damage combined single limits not less than one million, five hundred thousand dollars ($1,500,000.00).
13) CLS and CLS-FM Providers shall allow DIDD staff access to pertinent Choices member documentation as specified in TennCare protocol during DIDD critical incident investigations in CLS and CLS-FM blended residences in instances where the critical incident may impact all residents of the home (for example, staff misconduct). For the purpose of the Agreement and this Appendix, a CLS or CLS-FM blended residence is one in which at least one (1) Choices member and one (1) DIDD waiver participant receive services in the same CLS or CLS-FM residence.

14) CLS and CLS-FM Providers are required to comply with DIDD investigations as prescribed by TennCare protocol.

**SECTION 5
UNITEDHEALTHCARE REQUIREMENTS**

5.1 **Prompt Payment.** UnitedHealthcare shall pay Provider upon receipt of a clean claim properly submitted by Provider within the required time frames as specified in TCA 56-32-126 and section A.2.22.4 of the CRA as may be amended from time to time. Payments made via electronic transfers shall include a signed ETF form that includes 42 CFR 455.18 and 455.19 statements immediately preceding the “Signature” section. UnitedHealthcare shall pay Provider only for services (1) provided in accordance with the requirements of the CRA, UnitedHealthcare’s policies and procedures as set forth in the Agreement and this Appendix, and State and federal law and (2) provided to Covered Persons enrolled with UnitedHealthcare. Provider is responsible for (1) ensuring that any applicable authorization requirements are met and (2) verifying that a person is eligible for TennCare on the date of service.

5.2 **Third Party Liability.** If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the CRA. Provider shall identify third party liability coverage, including Medicare and long-term care insurance and if applicable, seek such third party liability payment before submitting claims to UnitedHealthcare. Unless UnitedHealthcare otherwise requests assistance from Provider, UnitedHealthcare will be responsible for third party collections in accordance with the terms of the CRA.

5.3 **Alternate Claims Processing.** In the event that the Bureau of TennCare deems UnitedHealthcare unable to timely process and reimburse claims and requires UnitedHealthcare to submit Provider claims for reimbursement to an alternative claims processor to ensure timely reimbursement, Provider shall agree to accept reimbursement at UnitedHealthcare’s contracted reimbursement rate or the rate established by the Bureau of TennCare, whichever is greater.

5.4 **No Incentives to Limit Medically Necessary Services.** UnitedHealthcare shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Covered Person.

5.5 **Provider Discrimination Prohibition.** UnitedHealthcare shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification. UnitedHealthcare shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting UnitedHealthcare from limiting a provider’s participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by UnitedHealthcare that are designed to maintain quality of care practice standards and control costs.

5.6 **Communications with Covered Persons.** UnitedHealthcare shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:
(a) The Covered Person’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment; or

(d) The Covered Person’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

UnitedHealthcare also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or authorization process to obtain necessary health care services.

5.7 Termination of Agreement. In addition to its termination rights under the Agreement, UnitedHealthcare shall have the right to suspend, deny, refuse to renew or terminate the Agreement in accordance with the terms of the CRA section E.14 and applicable law and regulation.

5.8 Sanctions. UnitedHealthcare shall have the right to assess liquidated damages, sanctions, or reductions in payment for specific failures to comply with contractual or credentialing requirements. This shall include, but may not be limited to, Provider’s failure or refusal to respond to UnitedHealthcare’s request for information, request to provide Medical Records, or request to provide credentialing information. At UnitedHealthcare’s discretion or a directive by TennCare, UnitedHealthcare shall impose financial penalties against Provider as appropriate. Such action shall be taken in accordance with the terms of the CRA and applicable law and regulation.

5.9 Provision of Materials to Provider. UnitedHealthcare will provide a copy of the applicable member handbook and Provider Manual to provider, and may do so via website at www.uhccommunityplan.com or other appropriate format.

5.10 Notice of Denied Authorizations. UnitedHealthcare will provide notice to Provider of any denied authorizations in accordance with the Provider Manual or other UnitedHealthcare policies and procedures.

5.11 Recoupment. UnitedHealthcare will not recoup payments made to Provider when the specific issue, services or claims that are the basis of the repayment are currently being investigated by TennCare or the State of Tennessee, are the subject of pending federal or State litigation, or are being audited by the TennCare Recovery Audit Contractor (RAC). UnitedHealthcare will seek permission from the Bureau of TennCare before initiating any recoupment of any program integrity related funds in compliance with section A.2.20.1.7 of the CRA, to ensure that the repayment is permissible. In the event UnitedHealthcare obtains funds in cases where repayment is prohibited, such funds shall be returned to Provider.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable CRA, as set forth in this Appendix, the Provider Manual, and protocols, policies and procedures that UnitedHealthcare has provided or delivered to Provider. No other terms or conditions agreed to by UnitedHealthcare and Provider shall negate or supersede the requirements of section A.2.12.9 or other applicable provisions of the CRA, which are incorporated into the Agreement by reference. It is UnitedHealthcare’s responsibility to provide all necessary training and information to Provider to ensure satisfaction of all UnitedHealthcare’s responsibilities specified under the CRA. Nothing in the Agreement relieves UnitedHealthcare of its responsibility under the CRA. If the Bureau of TennCare determines any provision of the Agreement is in conflict with provisions of the applicable CRA, the terms of the CRA shall control and the terms of the Agreement in conflict
with those of the CRA will be considered null and void. All other provisions of the Agreement shall remain in full
force and effect.

6.2 Monitoring. UnitedHealthcare shall perform ongoing monitoring of Provider and shall perform periodic formal
reviews, whether announced or unannounced, of Provider and of Covered Services rendered to Covered Persons,
consistent with the requirements of State and federal law and the applicable CRA. As a result of such monitoring
activities, UnitedHealthcare shall identify to Provider any deficiencies or areas for improvement mandated under the
CRA and Provider shall take appropriate corrective action where necessary to improve quality of care, in accordance
with that level of medical, behavioral health, or long-term care which is recognized as acceptable professional practice
in the respective community in which Provider practices and/or the standards established by the Bureau of TennCare.
Provider shall comply with any corrective action plan initiated by UnitedHealthcare.

6.3 Delegation. The parties agree that, prior to execution of the Agreement, UnitedHealthcare evaluated Provider’s ability
to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities
shall be set forth in the Agreement or other written delegation agreement or addendum between the parties.
UnitedHealthcare shall have the right to revoke any functions or activities UnitedHealthcare delegates to Provider
under the Agreement if in UnitedHealthcare’s reasonable judgment Provider’s performance under the Agreement
is inadequate.

6.4 Reassignment of Payment. Any assignment of TennCare funds or payments to billing agents or alternative payees
and any reassignment of payment must be made in accordance with 42 CFR 447.10 and shall require an executed
billing agent agreement or alternative payee assignment agreement. If the alternative payee assignment is on-going,
UnitedHealthcare or Provider, as applicable, shall screen the billing agents and alternative payees initially and
monthly through the federal exclusion (LEIE) and debarment (EPLS) databases. Any direct or indirect payments to
out of country individuals and/or entities are prohibited.

6.5 Entire Agreement. The Agreement, including the appendices, Provider Manual and policies and procedures referenced
in, and incorporated into, the Agreement and this Appendix contain the entire agreement of UnitedHealthcare and
Provider, and shall supersede all other oral agreements or negotiations between the parties. The Agreement, and any
renewal of the Agreement, shall include a signature page which contains UnitedHealthcare’s and Provider’s names
which are typed or legibly written, Provider’s company with titles, and dated signatures of all appropriate parties and
specify the effective date.

6.6 Amendment. This Agreement may be amended at any time by mutual agreement of the parties, provided that before
any amendment shall be operative and valid, it shall be reduced to writing and signed by UnitedHealthcare and Provider
and be attached to the Agreement. The only exception will be changes required to conform the contract to regulatory
requirements required by the State of Tennessee as described in Section 1 of this Appendix. All notification of amended
language will be documented (e.g., Certified Mail, facsimile, hand-delivered receipt, etc.). Provider shall have thirty
(30) days from the date that UnitedHealthcare sends notice of change to give notice of rejection. Notice of rejection
shall constitute termination without cause and require Provider to follow the termination provisions outlined in
the Agreement.

6.7 State Review and Approval. The Agreement and this Appendix, and any future revisions to the Agreement or this
Appendix, are subject to advance approval of TDCI in accordance with applicable State law regarding the approval of
a certificate of authority (COA) and any material modifications thereof. UnitedHealthcare shall revise the Agreement
and this Appendix as directed by the Bureau of TennCare. Further, the Bureau of TennCare shall have the right to
direct UnitedHealthcare to terminate or modify the Agreement when the Bureau of TennCare determines it to be in
the best interest of the State.
6.8 **Termination of CRA.** UnitedHealthcare and Provider recognize and agree that in the event of termination of an applicable CRA, Provider shall immediately make available to the Bureau of TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to Provider's activities under taken pursuant to the Agreement. The provision of such records shall be at no expense to the Bureau of TennCare. Provider shall continue to provide Covered Services under the terms and conditions of the Agreement for up to forty-five (45) calendar days from the termination date or until Covered Persons can be transferred to another managed care organization, whichever is longer. UnitedHealthcare shall continue to reimburse Provider for Covered Services through the end of UnitedHealthcare's obligations under the CRA.

6.9 **Governing Law.** The parties acknowledge that any disputes arising out of TennCare program services or items provided pursuant to the CRA shall be governed by and construed in accordance with the law of the State of Tennessee.

6.10 **Escalators.** As provided at Section 2.13.2.2 in the CRA between UnitedHealthcare and TennCare, the parties agree that UnitedHealthcare shall not reimburse Provider based on automatic escalators or linkages to other methodologies that escalate such as current Medicare rates or inflation indexes unless otherwise allowed by TennCare.