Division of TennCare

# MEMO

**To:** TennCare Managed Care Organizations (MCOs)
**From:** Keith Gaither, Managed Care Operations Director
**Date:** April 21, 2020
**Subject:** COVID-19 Guidance

This memorandum provides additional guidance and information regarding administrative changes to allow providers to better address the challenges associated with COVID-19.

**Acute Care Hospital-based Services – Utilization Management**

TennCare MCOs will continue to require notification and the submission of clinical information that is normally required for UM level of care reviews. However, the MCOs will refrain from denying claims or conducting the normal UM level of care review processes from 4/16/20 going forward. MCO's will not retract prior determinations completed; appeals and provider payment disputes will follow the usual process.

MCOs should continue the suspension of denying claims for notification not being timely filed or for UM not being timely filed.

**Post-Acute Care Services – Utilization Management**

TennCare MCOs will eliminate the requirement for authorization reviews before patients can be moved from the acute care setting to the appropriate post-acute care setting.

TennCare MCOs will also support rapid placement and discharge of currently hospitalized patients who can be safely discharged to another setting.

**Pharmacy & Medical Devices**

MCOs shall reimburse providers at the contracted rate for drugs dispensed from hospital pharmacies.

The MCOs will not require that any prescription drugs be dispensed by specialty pharmacy instead of the hospital pharmacy.

MCOs will offer appropriate reimbursement for any emerging drug treatments or devices for treatment of known or suspected COVID-19 patients.

Requests for the use of experimental drugs or devices should receive expedited review. The MCOs will be mindful of the need to be flexible in reviewing these requests, recognizing there is not currently a cure for COVID-19.

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**Readmissions**

Consistent with the practice of most payers, TennCare MCOs normally bundle the payment of a readmission with the original admission if the two stays are within 30 days of each other and other conditions are met. From April 21 forward to May 15, the MCOs will pay for the readmission separately. Note that the MCOs are not required to make this change retrospectively.

**Suspension of PCP Assignment**

The MCOs should continue the suspension of the practice of denying PCP service claims submitted by providers who are not the PCP of the members they are serving. Members will continue to be assigned PCPs, however.

**New Codes for COVID-19 testing**

TennCare MCOs have loaded all new COVID-19 testing and diagnosis codes. As new codes are made available, the MCOs should work to configure and be ready to accept them as quickly as possible an notify hospitals of further changes using their portals and as well as notifying THA.

**Lab Exception/Exclusion List**

MCO should add flu and COVID-19 testing to the exception/exclusion list.

**Internal and external appeals timeframes**

The timeframes for hospitals to submit appeals are typically 180 days. While we are not eliminating these appeals timeframes, if a hospital would like an extension, MCOs shall to review and approve reasonable requests on a case-by-case basis.

In addition, MCOs should consider the period and circumstances of this emergency in future audits.

**Not Requiring Medical Records Before Claims Adjudication**

TennCare MCOs will not request medical records before claims adjudication during this period (with the exception of ASH claims).

Note that this change will apply to inpatient and outpatient facility claims. We are not making this change for professional claims. Hospitals that have professional groups as part of their system may need to submit medical records for professional claims.

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**Medical Record Requests and Audits**

MCOs should suspend requesting medical records to reduce administrative burdens on hospitals. Audits or recoupments related to medical claims should be suspended or postponed during this period. MCOs should not place claims into either pre- or post-payment review or audit that would result in delay of payment of either stop-loss or outlier payments.

Note that this change will apply to inpatient and outpatient facility claims. This change does not apply to professional claims. Hospitals that have professional groups as part of their system may need to submit medical records for professional claims.

Future audits will consider the period and circumstances when the emergency occurred. However, because we are suspending most of the administrative measures in place to prevent inappropriate utilization during this period, once we have resumed normal operations, MCOs may review services during the period not just for fraud but also for waste or abuse. Reviews of services performed during this period should be reasonable.

**Services provided by practitioners not yet credentialed**

The MCOs are to pay for all services in the hospitals rendered by providers who are not yet credentialed. However, per federal requirements, all providers will need to have a Medicaid provider ID in order to be paid for Medicaid services.

**Recredentialling**

TennCare MCOs are suspending all recredentialling requirements for providers.

**Denials of Services Being Provided in Unlicensed Spaces**

TennCare MCOs will not deny services because they are provided in an unlicensed space.

**Services Provided by Hospitals in Non-traditional Locations**

Hospitals will be reimbursed under their existing contracts for services provided in non-traditional locations. Hospitals should continue to use current outpatient coding even when billing for non-traditional locations, while professionals can use the “99” location code to indicate that a claim is for a service in a non-traditional space.

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**Authorization Approvals Made Before the Emergency**

TennCare MCOs should adjust prior authorization approvals to move expiration dates forward so that they do not expire.

MCOs should also suspend site of service reviews during this period. In order to clarify what is being suspended, site of service refers to the least costly safe and appropriate place of service. For example, surgeries performed at Ambulatory Surgery Centers versus free standing facilities versus office settings. A site of service review looks at any co-morbid conditions that require more complex care, such as a request for Cystourethroscopy to be performed in a hospital outpatient surgical setting. If the member's clinical information showed comorbidities such as obesity, diabetes poorly controlled, and severe obstructive sleep apnea, a site of service review could approve the hospital as the appropriate site.

**Quality and Value-Based Payment Programs**

TennCare MCOs should postpone the manual collection of medical records for HEDIS and in-office reviews. Automated collection of data for quality measures will continue as there is no effort or intervention required from the provider.