Division of TennCare

MEMO

To: TennCare Providers
From: TennCare Appeals Staff
Date: May 23, 2018
Subject: Changes affecting your role in TennCare Patient Medical Services Appeal Process[i]

Effective January 1, 2018, new federal regulations necessitated changes to the appeal process by which TennCare enrollees may challenge adverse benefit determinations by managed care contractors.[ii] The following changes may impact your role in this appeals process.

- Written authorization required. In order to file an appeal on the enrollee's behalf, you must show that you have the enrollee's written authorization[iii] to do so. Whether the treating provider requests expedited or standard resolution of the appeal, the enrollee's written authorization is always required.

- Providers cannot request continuation of benefits (COB) on an enrollee's behalf. When an enrollee files an appeal contesting the MCC's decision to reduce or end a service currently being received, the enrollee has the right to keep getting that service until the appeal is resolved. However, even if you have authorization to file an appeal on enrollee's behalf, federal law now prohibits providers from requesting COB on an enrollee's behalf.[iv]

- Second opinions are no longer required for provider-initiated discharges from inpatient hospitals or from residential treatment. Although the treating provider must continue to confer two business days' advance written notice before an enrollee may be discharged from inpatient hospital treatment or from residential treatment, you need no longer perform a second opinion in order to initiate the enrollee's discharge.

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[i] Important: These changes have no bearing on the TennCare *provider* claim dispute process.
[ii] This appeal process allows TennCare enrollees to challenge adverse benefit determinations proposed by their managed care organization (MCO), dental benefits manager (DBM), or pharmacy benefits manager (PBM). This process also allows enrollees to challenge provider-initiated discharges from residential treatment. This is not the process by which providers may challenge an MCO's, DBM's, or PBM's *claim denial*—that process is unchanged and is handled by the Tennessee Department of Commerce & Insurance.
[iii] If the enrollee is a child, his parent or legal guardian must provide the authorization. If the enrollee is an incompetent adult, his legal guardian/conservator or agent must provide the authorization. For any other adult enrollee who has authorized a health-care representative, the representative may provide the authorization.
[iv] See 42 CFR §438.420(b)(5)

If the enrollee files an appeal contesting the proposed discharge and requests COB pending the appeal's resolution, the request for COB will be denied in view of the fact that the treating provider no longer prescribes the service. Once the PIN form is submitted to the health plan so that the enrollee's written notice can be issued, any additional days beyond the discharge date listed in the notice must be processed through the normal UM process. This includes a medical necessity review for a continued stay. Your PIN form is notification that the treating provider no longer recommends the service. Therefore, providers should not submit a PIN form until the member is ready for discharge, which includes having an appropriate discharge plan.