TennCare Oversight Division
500 James Robertson Parkway
Nashville, TN 37243

Phone: (615) 741-2677
Fax: (615) 401-6834
TennCare.Oversight@TN.gov

Request for Independent Review of Disputed TennCare Program Episode of Care Cycle Provider Gain/Risk Share Total

Please complete and submit by email (preferred) TennCare.Oversight@TN.gov, fax, or mail. We will acknowledge receipt of your Request by email. You will be copied on our correspondence concerning this matter by email. Please provide documentation that supports your dispute.

DO **NOT** send any Member Protected Health Information (PHI) via email unless you have HIPAA compliant encrypted email. PHI includes the member's name and other demographic information.

Requesting Provider Information

Provider Representative *Required field

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name*: _____ Last Name*: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Daytime / Alternate: _____

Fax Number: _____ Email Address: _____

Provider Name and National Provider Identifier (NPI)

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name*: _____ NPI#*: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Daytime / Alternate: _____

Fax Number: _____ Email Address: _____

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Health Plan Information

My Complaint is against Managed Care Company/Managed Care Organization ("MCC/MCO"):	☐ **Wellpoint (fka Amerigroup) (Wellpoint Tennessee HMO)** ☐ **United Healthcare Community Plan (UnitedHealthcare of the River Valley HMO)** ☐ **BlueCare (Volunteer State Health Plan HMO)** ☐ **TennCare Select (Volunteer State Health Plan HMO)**
Type of Episode:	Select One Episode from Dropdown

Provider Type: _____

Provider Type examples: Hospital, Physician, or Physician Group

Date(s) of Episode of Care Cycle Performance Report Period:

Start Date: _____ End Date: _____

Episode of Care Performance Report Date: _____
(Attach a copy of the Final Episode of Care Provider Performance Report)

Date Provider submitted written Reconsideration Request to MCC: _____
(Attach a copy of the Provider's Reconsideration Request)

Date Provider received written Reconsideration Denial: _____
(Attach a copy of the MCC's Reconsideration Denial)

TN Department of Commerce & Insurance

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Reason(s) for Dispute Not Reaching the Correct Total Gain/Risk Share:

- ☐ Average Cost calculated incorrectly
- ☐ All valid episode service claims not included
- ☐ Included claims that were not valid episode service claims
- ☐ Risk Sharing Factor was calculated incorrectly
- ☐ Report did not include the total number of cycle valid episodes (included and excluded)
- ☐ Risk adjustment methodology not based on the reports of risk markers and risk weight on the MCO's web site
- ☐ Episode Gain Sharing Limit incorrect
- ☐ Quality Metrics Acceptable Thresholds used not correct
- ☐ Quality Metrics Commendable Threshold used not correct
- ☐ Other

Only Episodes of Care Provider Performance Reports which meet ALL of the requirements set forth in T.C.A. § 56-32-126(b) (2) (A) thru (D) are eligible for Independent Review. Disputes involved in litigation, arbitration, or those not associated with a TennCare member are not eligible.

Please give a written description of the problem: (Attach additional pages if needed)

- **Description may include, but is not limited to, your position explaining why the value of the MCO's Total Gain/Risk Share is incorrect. Please include all pertinent information in your position description.**
- **Attach copies of pertinent documentation, including correspondence to and from the MCO, Episode of Care Quarterly Preview Reports, or remittance advice (as applicable) concerning this Episode of Care.**

_____

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_____

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Written description of the problem (continued):

_____

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT OF FEE OBLIGATION

By my signature below, I hereby request Independent Review of the above Episode of Care, pursuant to T.C.A. § 56-32-126(b). I also confirm that the above-mentioned disputed Episode of Care Provider Performance Report will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving an Episode of Care dispute raised in an Independent Review request before the Independent Reviewer renders a decision must ultimately pay the Independent Reviewer's fee. I also understand that there is a mandatory fee of $750.00 per claim and the MCO is initially responsible for paying the fee. I further, understand that if the Reviewer determines the calculation of the Episode of Care Cycle Total Gain/Risk Share is correct, then I must reimburse the MCO for the Reviewer's fee as established by the Selection Panel for TennCare Reviewers.

If you are NOT the aggrieved provider, what is your relationship to the provider: _____

I declare that the information I've furnished is true and accurate.

Signature: _____ **Date:** _____