Frequently Asked Questions

Q: I am billing for Inpatient Rehabilitation Services. Why was my claim Denied for "0388 - Services of this provider not covered by Medicaid"?

A: For TennCare to reimburse on an Inpatient Rehabilitation claim, the member must fall under one of the following categories: QMB, SSI Medicaid, (or) under the age of 21.

- If none of the above are true for the member, the service is considered non-covered.
- *For more information, refer to the links below:*
- Rule 1200-13-13 - TennCare Medicaid
  - Page 38, Inpatient Rehabilitation Facility Services
  - https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20190403.pdf
- Rule 1200-13-17 - TennCare Crossover Payments for Medicare Deductibles and Coinsurance
  - Page 4, Eligibility for Crossover Payments
  - https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-17.20131113.pdf

Q: I am billing an inpatient claim where a COPAY is due. Do I need to include coinsurance days?

A: No, you will not report coinsurance days when there is a COPAY due. You will only need to report coinsurance days when there is COINSURANCE due.

Q: Why was my claim returned back with a blank return to provider (RTP) form?

A: The RTP letter consists of two pages: the front of the page has a listing of the required form locators that need to be completed on the UB04 or CMS-1500. At the bottom of both RTP letters, there is an NCR Key with the numbers 1-10. When one or more of these numbers are circled, you will need to match the circled number(s) to the number glossary found on the second page (back of the RTP letter). Those corrections will need to be made prior to resubmission.

Q: What is TennCare's pricing methodology for injectable codes?

A: Effective May 31, 2017, all claims submitted for processing, regardless of the dates of service, will be subject to the correct pricing methodology for services resulting in 85% of Medicare allowed unless it is classified as an injectable service. Only HCPCS codes with a Berenson-Eggers Type of Service (BETOS) of O1D-CHEMOTHERAPY, O1E- OTHER DRUGS and O1G-INFLUENZA IMMUNIZATION

will be considered as an injectable service to be reimbursed at 100% and BETOS O1F-VISION, HEARING AND SPEECH SERVICES will pay at 100% on DME

provider types only. All other provider types billing injectable services will be reimbursed according to the TennCare Maximum Fee for Part B services, as noted in Rule 1200-13-17 TennCare Crossover Payments for Medicare Deductibles and Coinsurance. If prior to May 30, 2017, you were paid 100% for a code that was not classified as an injectable, TennCare has no intention to reprocess those claims.

For more information on the Medicare/Medicaid Crossover Payment Methodology, go online to www.tn.gov/TennCare → Policy & Guidelines → TennCare Rules → Chapter 1200-13-17 (Rule 1200-13-17-.01) paragraph numbers 24, 26, 28 and (Rule

1200-13-17-.04) paragraph numbers 1-7.

Q: What should I do with Remittance Advice "RA" from TennCare?

A: The RA reports payments with specific dollar amounts paid, payments with $0.00-dollar payments, and denials. Providers should post all three of these claims status reasons to their patient accounts to ensure accurate representation and status of claims processed by TennCare. This will assist providers in reconciling their accounts receivables and prevent unnecessary rebilling of claims to TennCare.

Q: What is the timely filing deadline?

A: TennCare requires claims to be filed within one (1) year from the date of service, or six (6) months from Medicare's pay date. If the claim was not paid within the timeframe, then it must be resubmitted every six (6) months from the date of the returned claim(s) or adjudication date. If this process is not followed, the claims would be untimely and will be denied accordingly.

The provider can use the Remittance Advice (RA) or the Return to Provider (RTP) letter, along with the claim form that was attached to the RTP letter, to prove timeliness. For each six (6) month resubmission, the claim(s) and matching Explanation of Benefits (EOB) must be provided with the claim as evidence for timely filing to be overridden.

NOTE: A phone call to the call center to inquire about a claim status will not qualify as evidence for resubmission.

Q: What documentation is needed to appeal a timely filing denial?

A: Should a claim be denied or returned to the provider unpaid, any resubmission or follow-up on the initial claim must be received by TennCare/Medicaid within six (6) months of the original denial date, and at least every six (6) months thereafter.

TennCare/Medicaid will not process submissions received after the six (6) months' time limit without the acceptable documentation described below.

Acceptable documentation includes:

1. Copies of Remittance Advice(s) from the Medicaid fiscal agent;

2. Copies of email(s)/letter(s) from the Medicaid fiscal agent, which specifically identify the claim;

3. Copies of email(s)/letter(s) from the crossover claims unit/TennCare Call Center, which specifically identify the claim;

4. Copies of dated Return to Provider (RTP) cover sheets (explaining why the claim failed to meet submission guidelines) along with the claim that was returned with the RTP sheet.

NOTE: Telephone calls, copies of claims, handwritten notations, spreadsheets, and copies of ledger cards or screen-shots from the provider's office or facility are **not acceptable**.

Q: Why are my CMS-1500 claims denying for TPL even though I submit the EOB from the Third Party Insurance Company with the claim?

A: TennCare/Medicaid is always the last payer source, so when there is a Third Party Liability (TPL) involved, you must follow the three (3) steps in order for the claim to

adjudicate:

1. The Medicare AND TPL EOB must be submitted with the CMS-1500 claim.
2. Complete the Division of TennCare's TPL form (in its entirety) for each claim to ensure correct adjudication.
3. Write "TPL Claim" on the envelope.

NOTE: Do not write instructions on the claim or its attachments**.** Please note that all three (3) steps must be followed in order to adjudicate a claim that involves a TPL policy.

Q: Why are my UB-04 claims denying for TPL even though I submit the EOB from the Third Party Insurance Company with the claim?

A: TennCare/Medicaid is always the last payer source, so when there is a Third Party Liability (TPL) involved, you must follow the four (4) steps in order for the claim to adjudicate:

1. In Form Locator 32 of the UB-04, you should use one of the following Occurrence Codes:
   - 24 – TPL Denial Date (List the TPL as a payer if no payment is made) attach TPL RA

     OR
   - 25 – TPL Termination Date (List the TPL as a payer if no payment is made) attach TPL term letter/notice
2. In Form Locators 50B-60B of the UB-04, list the payer name, along with policy number and paid amount, even if $0.00 payment was made.

****Last payer should always be Medicaid, spanning across form locators 50C- 65C****

3. Attach the Division of TennCare's TPL form.
4. Write "TPL Claim" on the envelope.

NOTE: Do not write instructions on the claim or its attachments. Please note that all four (4) steps must be followed in order to adjudicate a claim that involves a TPL policy.

Q: Why are mycrossover claims being denied?

A: Below are common reasons on why claims are being DENIED due to the enforcing of TennCare rules and regulations:

- Recipient is eligible in the SLMB Program
- Recipient not eligible for dates of service - no financial benefits
- Medicare allowed amount invalid or missing (resubmit claim and original Medicare Explanation of Medical Benefits [EOMB])
- Rendering provider not eligible on all dates of service
- Exact duplicate - detail
- Rendering provider not eligible to render services on dates of service
- NPI not submitted/valid/on file
- Zip code does not match the billing provider
- Procedure/Formulary age restriction
- Patient has two coverage types
- Submitted Billing NPI's taxonomy does not match to TennCare's system
- Submitted Billing NPI's tax ID does not match the record on file in TennCare's system
- Recipient name and recipient number does not match the record on file in TennCare's system
- Submitting Billing NPI type and specialty does not match the record on file in TennCare's system
- Claim billed is a duplicate of another claim (for example, same or different provider)
- Recipient has Third Party Insurance
- Submitted Billing NPI on the claim not found on file in TennCare's system
- Submitted Billing NPI address on the claim does not match the record on file in TennCare's system

Q: Why are mypaper crossover claims denying as duplicates?

A: If you have selected with Medicare to enable the automatic crossover of claims electronically to Medicaid, TennCare suggests that you allow at least 14 business days for the electronic submission to show in the system. If after the 14 business days the claim does not show on your weekly Remittance Advice or on TCOS, **contact the call center to check claimstatus before submitting a paper claim**.

Paper claims will deny as duplicates if the electronic crossover claims have been processed by TennCare. Submission of paper claims is an unnecessary cost and burden to providers, unless the electronic claim has been adjudicated incorrectly or needs to be adjusted by the provider as a result of a Medicare adjustment.

Q: My UB-04 claims are being returned for "*Service Date (FL45) Must Be Within Statement Covers Period Dates (FL06)*". Why?

A: All dates listed on the UB-04 (with the exception of the Date of Birth, Admission Date, Third Party Liability Pay/Deny Date (if applicable), and the Medicare Paid Date) MUST fall within the Statement Covers Period dates billed in Form Locator (FL) 06.

Since the Service Date (FL45) is not a required field, but situational, claims billed with Revenue Code 0022 should leave the date blank on the claim if it does not fall within the date range.

Q: Why am I required to submit a taxonomy code on claims to TennCare?

A: TennCare requires the taxonomy code for processing claims to enable correct adjudication. Providers who are registered with multiple provider types and specialties must submit the taxonomy code on the claim that coincides with the taxonomy code the provider reported during registration with TennCare.

On the CMS-1500, the taxonomy is to be reported in 33B for the Billing Provider with qualifier ZZ. For the Rendering Provider (on each detail line), qualifier ZZ is to be reported in 24I when the NPI in 24J is different than the Billing NPI. On the UB-04, the taxonomy is to be reported in 81CC with the qualifier B3 and the appropriate taxonomy code.

Q: My claim was denied for EOB Code 0432 (*Swing Beds Are Not a TennCare Covered Service*). Why?

A: When submitting a swing bed claim to TennCare, the following criteria must be met for the claim to adjudicate:

- Must be an inpatient claim
- Type of bill is 18X (Hospital Swing Beds) or 28X (Skilled Nursing Swing Beds)
- The recipient must have an active benefit plan of Qualified Medicare Beneficiary (QMB) for the claim's dates of service.

Q: My claim was denied for EOB Code 0848 (*DSNP XOVER - No Patient Responsibility Due*). What does this mean?

A: TennCare Dual-Special Needs Plan (DSNP) plans automatically submit electronic crossover claims to TennCare on your behalf. When claims deny for EOB Code 0848, this means the DSNP submitted the claim to TennCare with no deductible, coinsurance, or copay due.

Q: My claim was denied for EOB Code 2007 (Medicare Coinsurance Greater Than Medicare Paid) before mid-2017. Why?

A: Before October 2017, TennCare had been adjudicating claims to a DENIED status that have EOB Code 2007. Since then, providers should no longer receive denials for

this code on their Remittance Advice (RA). If providers should see this denial, they are instructed to resubmit the original red dropout claims.

If the claim(s) have exceeded timely filing, please attach a letter with the claim(s) requesting override for timely filing and the RA showing the DENIED status. Attaching the documentation is proof that the claim was denied within the timely filing period.

Additionally, please write “O/R Timely Filing” on the outside of the envelope to ensure claims are processed correctly to prevent rework. These claims should be submitted to the appropriate P.O. Box. For a complete listing of the P.O. Boxes, please visit:

https://www.tn.gov/tenncare/providers/current-po-box-list.html

Q. Why has my adjustment not been processed?

A: Refer to your Remittance Advice (RA) to check the status (PAID or DENIED) of the claim you would like to adjust. All supporting documentation will need to be submitted with the A/V form. Claims submitted for an adjustment can only process against a PAID claim and a complete A/V form.

NOTE: If an adjustment has been submitted against a DENIED claim (or a previously adjusted DENIED claim) or the A/V form is not filled out properly (for example, Insurance Company missing, Claim # missing Provider Signature and Date Missing, etc.), it shall fail to process in our system and will result in a Return to Provider (RTP) letter.

Q: I was informed not to send paper claims to TennCare via certified mail. Why?

A: Our contracting mailroom staff are receiving more certified packages than regular mail. Certified mail has increased the number of steps to process claims (for example, Log tracking numbers, creating copies of the envelope, special handling, etc.). This process not only impacts our mailroom staff, but also our entire claims processing structure.

Claims are reviewed/processed by receipt date order. Sending claims in certified mail does not guarantee that your claim will reach an adjudicated status as they may be returned for missing/incorrect information.

PLEASE DO NOT SEND YOUR CLAIMS VIA CERTIFIED MAIL.

If you have questions on claims that have been submitted through certified mail, **please reach out to our call center** and give the following information:

- Certified letter number
- Date in which the package was signed
- By whom it was signed
- Last Name and First Name, along with the Recipient ID for each claim
- Dates of service for each claim
- Total amount billed for each claim
- Billing NPI for each claim

The call center will send the information to our contractor for review. They will research

and reach out to the provider and communicate their findings on what has happened with the claim(s) in question (for example, if they have been processed OR if they were returned to the billing address).

Q: Why can I not submit a spreadsheet for processing claims that I have already sent to TennCare?

A: Our contracting staff cannot process a claim unless a matching EOB/EOMB is attached. A spreadsheet does not contain the required detailed information for a claim to be processed under TennCare billing guidelines.

Q: I am being told that my claims are not in the system, even after mailing to TennCare multiple times. Why is this happening?

A: If you are told by the call representative that your claim is not in the system, this means that the representative is not able to provide you with a "suspended, paid, or denied" status for your claim*. This does not mean your claims have been lost or destroyed,* as all documents received are scanned into TennCare's image repository and have a system tracking number applied to each document.

Q: When I contact the Call Center, I am told that they cannot find/locate my paper claim, why?

A: *This does not mean your claims have been lost or destroyed*. While all claim(s) images are in the image repository with a system tracking number, it was discovered that the system was not able to connect the claims image to the provider and/or recipient file for easy retrieval. As of 04/27/2018 and forward, claim images can now be retrieved within the repository system using required fields (for example, Provider NPI and/or Recipient Identifier/SSN). Claims received prior to this date can be found, but must be manually researched by a range of dates close to when the provider communicates that the claim was mailed. TennCare receives thousands of claims from providers daily, so research involves reviewing thousands of images to locate claim(s), which can take a significant amount of time to locate.

Q: I spoke to a Call Center representative and was told that my claim was rejected and was mailed back with an RTP Letter, but I have yet to receive it in the mail. Why have I not received it yet?

A: If your billing services are performed at a different location other than the address listed on the claim(s) (Form Locator 1 on the UB-04 and Box 33 on the CMS-1500), please contact your billing location to receive information on claims that have been returned.

Q: Why was my claim returned back to the provider (RTP'd) with Manual Review Reject checked?

A: Claims that fail the prescreening process (for example, Submit EOMB for each claim, Billing NPI missing, etc.) will be RTP'd with a letter indicating the Manual Review Reject (as seen in the upper-right hand corner of the letter), the reason for return, and the original claim form and/or attachments that are needed for correction**.** Consequently, providers must correct the claim and resubmit the new claim form along with EOB and any necessary attachments (for example, RTP letter if trying to prove timely filing, cover letters, etc.), which will apply a new receipt date to the corrected claim.

If there is no visible reason on the front facing of the RTP letter, please check "*See back of form for more information"* to review the back of the form for additional reasons.

Q: Why was my claim returned back to the provider (RTP'd) with OCR Reject checked?

A: Claims that pass the prescreening process are routed through to our claims processing system. Prescreened claims are not guaranteed for claim adjudication. Those that fail to process (for example, Broken/Light characters, alignment issue, etc.) are rejected in the claims processing system, as indicated by the OCR Reject indicator on the RTP letter.

Below are common reasons on why claims are now being rejected due to the enforcing of TennCare rules and regulations:

- Light print/broken characters on claim form (Ink needs to be in a legible dark ink to be read by the Optical Character Recognition software)
- Invalid font (Correct font needs to be Courier New or Times New Roman, using the incorrect font causes processing delays in the claim adjudication process (for example, I110 can be read as 1110)
- Alignment issue with claim (Implement a print test before printing claims)

- EOB/EOMB not attached or does not match
- Billing and/or secondary NPI not on file
- Invalid Recipient Identifier (Can only be Medicaid ID [11 digits] or SSN [9 digits])

Q: Why is there a delay in receiving my rejected/RTP paper claims in the mail?

A: TennCare mails paper claims through USPS to the Billing address that is listed on the claim. If the Billing address listed on the claim does not match to the USPS database, your mail may be delayed.

It is imperative that providers print the correct USPS physical address and phone number of the provider (FL1 on the UB04-1450 form and Box 33 on CMS-1500 form) to minimize possible interruption in receiving returned mail and to enable contact via phone for questions concerning claims. Please reference the link to the USPS website https://tools.usps.com/go/ZipLookupAction_input to verify your valid USPS address.

Q: What two (2)-digit qualifier should I use in form locator 33B of the CMS-1500 when submitting a crossover claim via paper?

A: TennCare ONLY uses qualifier ZZ + taxonomy in form locator 33B.

NOTE: Qualifier 1D should never be used on a paper claim, qualifier 1D is used on the electronic submissions only.

Amendment History

Summary of Change

Version #	Modified Date	Modified By	Section, Page(s) and Text Revised
7.1	02/14/2020	Tammy Gennari	Added new Inpatient Rehabilitation Services Q & A to beginning of document
7.2	02/24/2020	Kendra Beattie	Reviewed document; updated footers and document version
8.0	02/24/2020	Tammy Gennari Kendra Beattie	Final author review performed